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Alcohol and Drug Research Newsletter

Drugnet Ireland
10 years on: what have we learned?

See page 12

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The value of education in drug rehabilitation: report of new research

At the launch of the report: Gerry McAleenan of Soilse, Prof Joe Barry of TCD, and author of the report Martin Keane of the HRB (Photo: JJ Berkeley)

Councillor Emer Costello (former Lord Mayor of Dublin) launched a research report in October 2011 on the role and benefits of education in drug rehabilitation and recovery from addiction.[1] The report is derived from an analysis of data from in-depth interviews with 20 individuals in recovery from substance addiction.

All of the people interviewed had progressed through the Health Service Executive (HSE) Soilse drug rehabilitation programme. The data were analysed using the recovery capital framework, which looks at social, physical, human and cultural outcomes. The framework was initially developed by Granfield and Cloud in 1999[2] in their study of 46 individuals who overcame substance dependence without the aid of formal treatment or recourse to self-help groups, and refined by the same authors in 2008.[3] The present study with former participants in the Soilse programme was the first attempt to apply the construct of recovery capital to addiction recovery in Ireland.

Most of the interviewees were early school leavers, with modest formal educational achievements, little in the way of sustained employment and a history of having experienced conflict in the home. Since becoming involved in adult education through Soilse, most had achieved third-level degrees or diplomas.

According to Cloud and Granfield,[3] recovery capital is the sum of resources necessary to initiate and sustain recovery from substance misuse. The authors identify four dimensions to recovery capital:

Social capital – the sum of resources that each person has as a result of their relationships, support from and obligations to groups to which they belong.

Physical capital – tangible assets such as property and money that may increase recovery options.

Human capital – personal skills and education, positive health, aspirations and hopes; key aspects of human capital, and will

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contents

The value of education in drug rehabilitation *(continued)*

help with some of the problem solving that is required on a recovery journey.

Cultural capital – values, beliefs and attitudes that link the individual to social attachment and the ability to fit into dominant social behaviour.

Study findings

This study of 20 people in self-reported recovery from substance addiction demonstrated the contribution that education can make to developing recovery capital. Education played a role in all four dimensions for the participants in this study: it improved social capital by opening up opportunities to develop new networks of friends outside the confines of formal treatment and self-help groups; it improved physical capital by improving career options and job opportunities, which can improve living standards; and it improved cultural capital by exposing people to new values, beliefs and attitudes and instilling a revised work ethic grounded in the demands of educational pursuits. Finally, education contributed to recovery capital by improving human capital, empowering these people to look after their health, become more effective parents, reappraise ingrained negative belief systems, develop achievable goals and improve day-to-day functioning and personal efficacy.

Official treatment programmes can play a vital role in halting addiction and promoting recovery and can benefit people on a number of therapeutic levels. However, when people emerge from treatment they need to transfer these benefits into day-to-day living and also navigate their way into and through real-life situations. Returning to adult education can enable people in recovery to build sufficient recovery capital to assist them on this journey and help them to reproduce their recovery on a day-to-day basis. Drug policy and practice can be strengthened by giving renewed emphasis to the role of education in developing recovery capital. Finally, engaging with adult education while in recovery can open up opportunities for people that can provide them with rewards which they will not risk losing, such as legitimate income, sustainable housing, improved relations with family and a sense that they belong to a community. The importance of these components of sustained recovery is neatly encapsulated by Neale.[4]

> Recovery will only occur if drug users believe that abstinence has more to offer than addiction. Accordingly, recovering drug users must find a purpose for their drug-free lives. To this end, they need meaningful roles and activities that offer them self-respect and pride, and daily routines that do not involve criminal or drug-using activities. …the conditions that seem likely to facilitate successful rehabilitation are the same kinds of conditions that probably prevent drug misuse in the first place. That is, access to a decent income; adequate housing; employment opportunities; family relationships; and being connected to community networks. …these are also key factors motivating most non-addicted members of society... (pp. 218–219)

(Martin Keane)

1. Keane M (2011) *The role of education in developing recovery capital in recovery from substance addiction*. Dublin: Soilse Drug Rehabilitation Project.
2. Granfield R and Cloud W (1999) *Coming clean: overcoming addiction without treatment.* New York: New York University Press.
3. Cloud W and Granfield R (2008) Conceptualising recovery capital: expansion of a theoretical construct. *Substance Use and Misuse,* 43 (12–13): 1971–1986
4. Neale J (2002) *Drug users in society*. Basingstoke: Palgrave Macmillan.

Trends in treated problem alcohol use

A recent addition to the HRB Trends Series, *Treated problem alcohol use in Ireland 2005 to 2010*,[1] was published in November 2011. Number 11 in the series, the paper is based on data reported to the National Drug Treatment Reporting System (NDTRS). It is important to note that the reporting system collects data on episodes of treatment, rather than the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years. The main findings of the paper are summarised below.

Numbers treated

In the period 2005–2010, a total of 42,333 cases presented with alcohol as a **main problem substance**, accounting for more than half (52.7%) of all cases treated for problem substance use during that period.

Trends in treated alcohol use *(continued)*

The incidence of such cases increased from 109.9 per 100,000 of the 15–64-year-old population in 2005 to 133.2 per 100,000 in 2010. The prevalence increased from 187.6 per 100,000 in 2005 to 251.6 per 100,000 in 2010. This is an indication that problem alcohol use is a recurring addiction that requires repeated treatment over time.

These increases in incidence and prevalence may be explained by a true increase in problem alcohol use in the population, an increase in reporting to the NDTRS, or a combination of both.

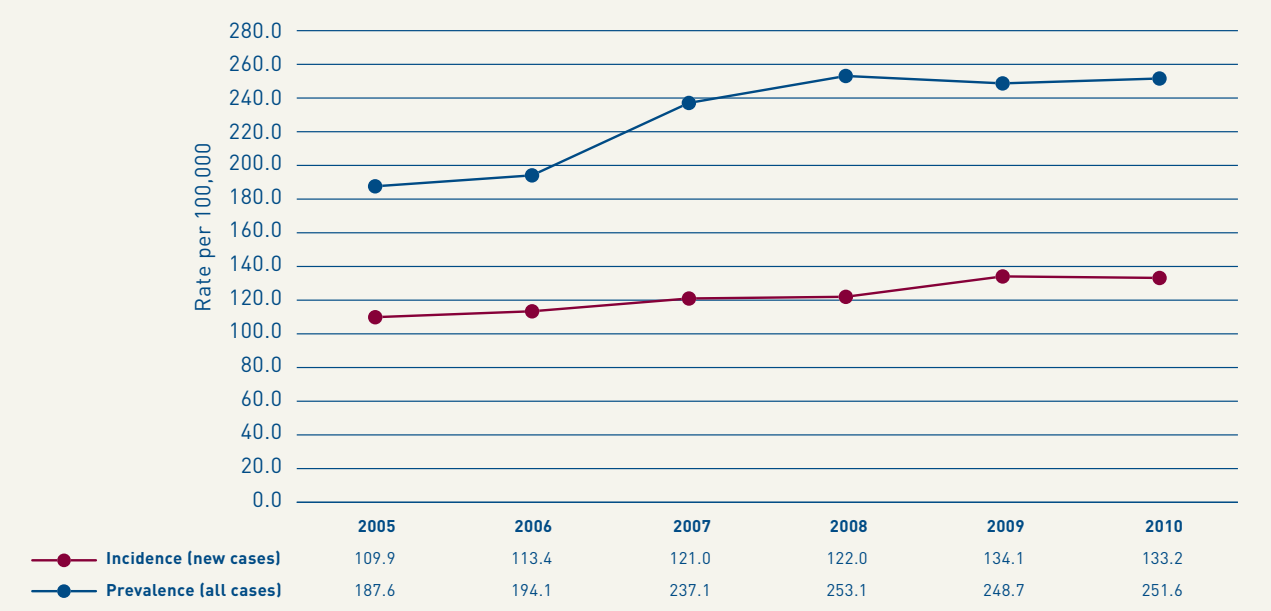


Figure 1 Incidence and prevalence of cases per 100,000 of the 15–64-year-old population (NDTRS 2005–2010)

The incidence of cases treated for alcohol as a main problem drug was analysed by county for two distinct time periods: 2005–2007 and 2008–2010. In the period 2005–2007 the incidence rates per 100,000 of the 15–64-year-old population were highest in Sligo, Donegal, Leitrim, Waterford, Cavan and Wexford (with more than 200 cases per 100,000), and lowest in Mayo, Roscommon and Galway. The rates were also low in Dublin and Wicklow (with less than 100 cases per 100,000). These low rates may be explained by low levels of participation in the NDTRS by services in these counties prior to 2007. In the period 2008–2010 the incidence rates were highest in Waterford, Leitrim and Donegal and lowest in Wicklow, Clare and Laois.

The annual number of cases increased from 5,525 in 2005 to 7,866 in 2010. This increase reflects the growing number of treatment centres participating in the NDTRS, but may also point to an increase in the number of people presenting for treatment.

The number of new cases rose by 29.4%, from 3,228 in 2005 to 4,178 in 2010. The number of previously treated cases also increased (by 60.7%), from 2,229 in 2005 to 3,583 in 2009.

The largest proportion (39.4%) of cases in 2010 lived in the HSE South Region, and more than one quarter (25.6%) lived in the HSE West Region.

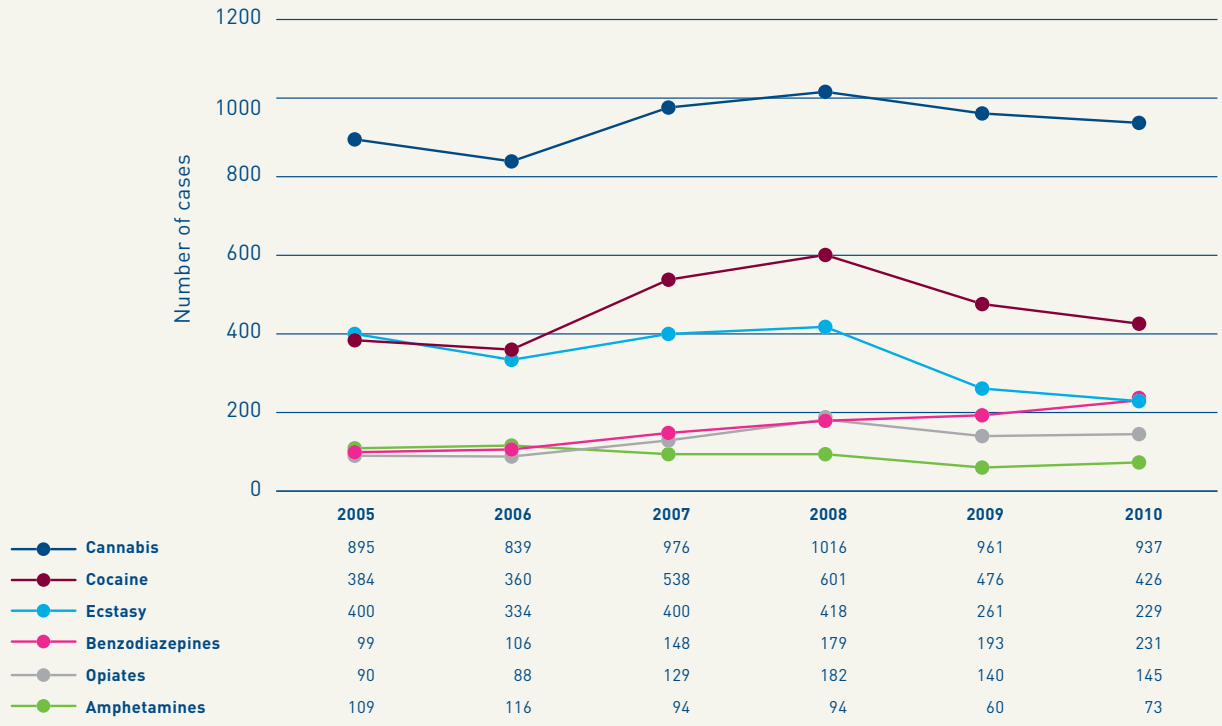
Table 1 Number (%) of cases treated, by treatment status (NDTRS 2005–2010)

Treatment status	2005		2006		2007		2008		2009		2010	
	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
All cases	5525		5874		7312		7940		7816		7866	
New cases	3228	(58.4)	3431	(58.4)	3736	(51.1)	3833	(48.3)	4220	(54.0)	4178	(53.1)
Previously treated cases	2229	(40.3)	2344	(39.9)	3110	(42.5)	3606	(45.4)	3524	(45.1)	3583	(45.6)
Treatment status unknown	68	(1.2)	99	(1.7)	466	(6.4)	501	(6.3)	72	(0.9)	105	(1.3)

Substances used in conjunction with alcohol

Almost one in five of those treated for alcohol as a main problem substance also reported using at least one other substance. In 2010, the most common drugs used in conjunction with alcohol were cannabis, cocaine, benzodiazepines and ecstasy. This reflects a minor change since 2008, when opiates were the fourth most common additional drug. Use of more than one substance increases the complexity of cases and leads to poorer outcomes for the patient. Information about combinations of substances used is important in terms of individual clients' care plans.

Trends in treated alcohol use *(continued)*



	2005	2006	2007	2008	2009	2010
Cannabis	895	839	976	1016	961	937
Cocaine	384	360	538	601	476	426
Ecstasy	400	334	400	418	261	229
Benzodiazepines	99	106	148	179	193	231
Opiates	90	88	129	182	140	145
Amphetamines	109	116	94	94	60	73

Figure 2 All cases: additional problem substances associated with alcohol as a main problem substance (NDTRS 2005–2010)

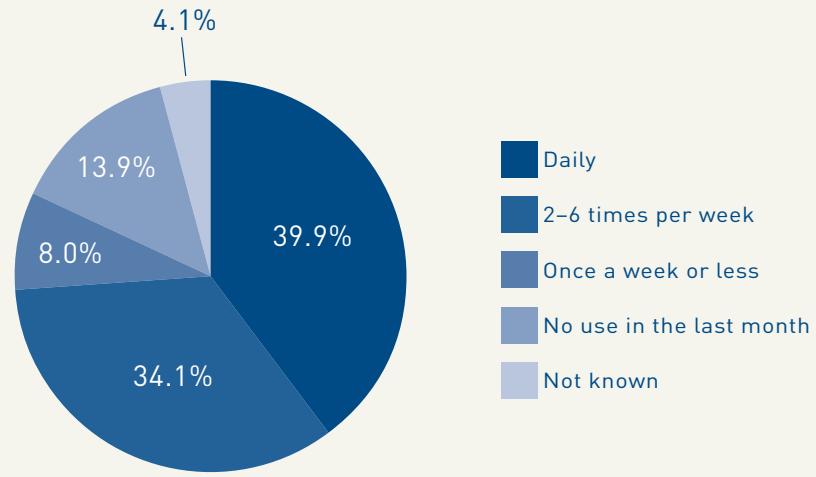


Figure 3 Frequency of alcohol use in the month prior to treatment (NDTRS 2005–2010)

Patterns of alcohol use

The largest percentage (39.9%) of cases in the period 2005–2010 reported using alcohol daily (Figure 3).

In 2010, 31.0% used alcohol daily, 38.1% used it between two and six days per week, 9.0% used it once per week or less, and 17.5% had not used it in the month prior to entering treatment. In the same year, the figure for 'daily use' was higher for previously treated cases (33.2%) than for new cases (29.4%).

Half of all cases had begun drinking by the age of 16 years. This was true for new and previously treated cases. Of those who reported ever using drugs (10,336, 25.4%), the median age at which they commenced the illicit use of drugs remained constant over the reporting period. By the time they were 16 years old, half of all those treated for problem alcohol use had commenced the illicit use of drugs (excluding alcohol and tobacco).

Trends in treated alcohol use *(continued)*

The median age at which new cases commenced treatment was 36 years. Half of the new alcohol cases had used alcohol for 19 years or more before seeking treatment.

Socio-demographic characteristics

Half of those treated for alcohol as a main problem substance were aged 40 years or under. The age profile of cases remained similar throughout the reporting period. The median age for all treated cases was 39 years; the median age for new cases continued to be lower (36 years). While the proportion of cases aged under 18 years remained small, the number of new cases in that age group rose by 151.9% in the reporting period.

The socio-demographic characteristics of cases, both new and previously-treated, remained similar throughout the reporting period. The majority of cases were male, with low levels of employment. The proportion of cases in employment fell in the years 2008 to 2010, possibly reflecting the current economic climate. The proportion of cases who were homeless fell slightly between 2008 and 2009, but rose again in 2010: new cases from 2.4% to 1.5% to 2.3%, and previously-treated cases from 6.9% to 5.0% to 6.5%. Those who used other substances as well as alcohol were more likely to be unemployed and to live in unstable accommodation.

The findings and their implications are presented in detail in the Trends Series paper. An online Appendix to the paper, containing additional tables and figures with supplementary data, is available at www.drugsandalcohol.ie/16037

(Anne Marie Carew)

1. Carew AM, Bellerose D and Lyons S (2011) *Trends in treated problem alcohol use in Ireland 2005 to 2010*. HRB Trends Series 11. Dublin: Health Research Board. www.drugsandalcohol.ie/16037

2011 report on the drugs situation in Europe

The annual report for 2011[1] from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was published on 15 November. The Health Research Board (HRB) provides the Irish figures for the EMCDDA report.

The report shows drug use to be relatively stable in Europe, with some positive signs that cocaine use may have peaked and that cannabis use continues to decline among young people in many countries. The number of new cases entering treatment for problem cocaine use has declined over the past two years, indicating a possible decrease in cocaine use in Ireland. The 2007 Health Behaviour in School-aged Children (HBSC) survey shows a small increase in lifetime cannabis use among schoolchildren over three time points, indicating that cannabis use continues to increase among young people in Ireland.

Signs of stability in relation to some of the more established drugs are offset by new threats across Europe. Over the last nine years, and more intensively over the last three to four years, the selling of new psychoactive substances in head shops and online has emerged as a new phenomenon across Europe, including Ireland.

Opiates (mainly heroin)

Around 5% of those entering treatment for drug problems now report opiates other than heroin as their primary drug; this proportion is much higher in Northern Europe. For instance, three quarters of those entering treatment in Estonia now report fentanyl, a synthetic opiate, as their main problem drug. In Ireland around 2% of those entering treatment for drug problems reported opiates other than heroin as their primary drug.

Among opiate users entering treatment, rates of injecting vary considerably between countries, ranging from under 10% in the Netherlands to over 90% in Latvia and Lithuania. However, a five-year analysis of trends among heroin users entering treatment shows that the proportion of those reporting injecting (40% in 2009) is falling in most European countries. In Ireland 36% of heroin users entering treatment reported injecting drug use. The proportion of injector cases has decreased since 2005. The EMCDDA estimates that between 10,000 and 20,000 opiate users die each year from overdose, disease, suicide and trauma. The report estimates that the mortality rate among regular opiate users is 10 to 20 times higher than that among their non-opiate-using peers. Opiates continued to be associated with the majority of fatal overdoses in Ireland. In 2009, 180 poisoning deaths were associated with opiates, alone or with another drug. A total of 1,345 non-poisoning deaths were recorded among drug users between 1998 and 2007; 60% were due to trauma (mainly hangings and road traffic collisions) and 40% were due to medical causes (mainly cardiac events and respiratory infections). The proportion attributable to opiate use has not been calculated.

The availability of heroin was reported to have dropped in a number of European countries at the end of 2010 and in early 2011, with the drought being particularly evident in the UK and Ireland. (See Quantitative evidence of a heroin drought on page 21 of this issue.)

Cocaine

Of the five high-prevalence countries, four – Denmark, Spain, Italy and the UK – reported a decline in last-year cocaine use among young adults. Ireland is ranked fifth for cocaine use in the EU. The 2010/11 NACD general population survey[2] reported that 1.5% of adults had used cocaine in the year prior to the survey and that the percentage was higher among young adults (2.8%) and among men (2.3%). Around 17% of drugs users entering treatment reported cocaine as their main problem drug. In Ireland in 2009, 11% of those who entered treatment reported cocaine as their primary drug; this proportion fell to 9% in 2010.

Cannabis

Cannabis is still Europe's most commonly consumed illicit drug. One in five adults aged 15–64 years have tried cannabis at some point in their lives. The latest European data confirm the general stabilisation or downward trend in cannabis use among young adults (15–34 years). Surveys of school children mirror this decline. Ireland is placed in the mid-range for cannabis use. The 2010/11 NACD general

2011 report on the drugs situation in Europe *(continued)*

population survey reported that 6.0% of the general population had used cannabis in the year prior to the survey. The number of cannabis users attending treatment increased from 991 in 2003 to 1,893 in 2010, when it represented 25% of all clients in treatment.

New psychoactive substances

The European Early Warning System identified 24 new psychoactive substances in 2009, 41 in 2010 and 34 in 2011. The most recent EMCDDA snapshot survey of online retailers selling new psychoactive substances identified over 600 online shops, almost twice as many as a year ago. The survey also revealed a variety of new products, an increase in warnings, restrictions and disclaimers. It also revealed an increasing ability to mask the identities of both sellers and buyers. Ireland has had notable success in limiting the sale of new psychoactive substances. This was achieved through the combined efforts of a number of government departments and statutory agencies.

(Brian Galvin)

1. EMCCDA (2011) *Annual report 2011: the state of the drugs problem in Europe.* Luxembourg. Publications Office of the European Union. www.drugsandalcohol.ie/16288
2. National Advisory Committee on Drugs. (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/2011 drug prevalence survey.* Dublin. National Advisory Committee on Drugs & Public Health Information and Research Branch. www.drugsandalcohol.ie/16353

Results from the third general population survey in Ireland

On 22 November 2011, the National Advisory Committee on Drugs (NACD) and and the Public Health Information and Research Branch (PHIRB) of the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland published jointly the results of the third all-Ireland general population drug prevalence survey.[1] These surveys are done every four years. This article presents a summary of the methods and results for Ireland.

The 2010/11 survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the European Model Questionnaire, was administered in face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland. The questionnaire had been revised to include better measures of problematic alcohol and cannabis use, and three questions about new psychoactive substances sold in head shops or online. The detailed results from these new questions will be published in future bulletins. The response options for questions about other opiate-type substances used were increased to include codeine and other commonly used opiates; this may account for the increase in the use of other opiates when compared to the previous surveys. Fieldwork was carried out by MORI MRC during late 2010 and early 2011. Of the household members contacted, 5,134 (60%) agreed to take part. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use).

Use of any illegal drug

Compared with the previous survey, the proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by just over 3%, from 24% in 2006/7 to 27.2% in 2010/11 (Table 1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased, by just over 4%, from 31.4% in 2006/7 to 35.7% in 2010/11. As expected, more men (35.5%) reported using an illegal drug in their lifetime than women (19%).

The proportion of adults who reported using an illegal drug in the last year remained reasonably stable at 7.2% in 2006/7 and 7% in 2010/11 (Table 1). The proportion of young adults who reported using an illegal drug in the last year also remained stable, at 12.2% in 2006/7 and 12.3% in 2010/11. The proportion of young adults who reported using an illegal drug in the last month was 5.3%.

Table 1 Lifetime, last-year and last-month prevalence of illegal drug use in Ireland, 2002/3, 2006/7 and 2010/11

Illegal drug use*	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	18.5	24.0	27.2	23.8	29.5	35.5	13.1	18.6	19.0	25.9	31.4	35.7
Last year	5.6	7.2	7.0	7.8	9.8	10.4	3.4	4.7	3.6	9.8	12.2	12.3
Last month	3.0	2.9	3.2	4.1	4.5	5.3	1.8	1.4	1.1	5.2	5.0	5.3

*Amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011)

Cannabis use

Lifetime cannabis use increased over the four years since the 2006/7 survey, but last-year use remained stable (Table 2). The proportion of adults who reported using cannabis at some point in their life increased from 21.9% in 2006/7 to 25.3% in 2010/11. The proportion of young adults who reported using cannabis in their lifetime also increased, from 28.6% in 2006/7 to 33.4% in 2010/11. The lifetime prevalence rate in 2010/11 was higher for men (33.2%) than for women (17.5%).

Results from the third general population survey *(continued)*

The proportion of adults who reported using cannabis in the last year did not decrease significantly in 2010/11 (6.0%) when compared to 2006/7 (6.3%). The proportion of young adults who reported using cannabis in the last year remained reasonably stable over the last two survey periods (Table 2). The proportion of adults who reported using cannabis in the last month remained stable also, at 2.8%.

Table 2 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3, 2006/7 and 2010/11

Cannabis use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	17.3	21.9	25.3	22.2	27.2	33.2	12.3	16.8	17.5	23.8	28.6	33.4
Last year	5.1	6.3	6.0	7.2	8.8	9.1	2.9	3.9	2.9	8.6	10.6	10.3
Last month	2.6	2.6	2.8	3.4	4.1	4.7	1.7	1.2	0.9	4.3	4.3	4.5

Source: National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011)

Cocaine use

Lifetime cocaine use increased in 2010/11 compared to 2006/7, but last-year use remained stable. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5.3% in 2006/7 to 6.8% in 2010/11 (Table 3). The proportion of young adults who reported using cocaine in their lifetime also increased, from 8.2% in 2006/7 to 9.4% in 2010/11. More men (9.9%) reported using cocaine in their lifetime than women (3.8%).

The proportion of adults who reported using cocaine in the last year remained reasonably stable at 1.7% in 2006/7 and 1.5% in 2010/11 (Table 2.2.3). The proportion of young adults who reported using cocaine in the last year did not vary significantly, being 3.1% in 2006/7 and 2.8% in 2010/11. The proportion of adults who reported using cocaine in the last month remained stable at 0.5%.

Table 3 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7 and 2010/11

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.0	5.3	6.8	4.3	7.1	9.9	1.6	3.5	3.8	4.7	8.2	9.4
Last year	1.1	1.7	1.5	1.7	2.3	2.3	0.5	1.0	0.7	2.0	3.1	2.8
Last month	0.4	0.5	0.5	0.7	0.8	0.8	0.0	0.2	0.3	0.7	1.1	1.0

Source: National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011)

Ecstasy use

Almost 11% of young adults surveyed in 2010/11 claimed to have tried ecstasy at least once in their lifetime (Table 4). More young men (15%) reported using ecstasy in their lifetime than young women (6%). The proportion of young adults who used ecstasy in the last year decreased significantly, from 2.4% in 2006/7 to 0.9% in 2010/11. The decrease in ecstasy use may be partly explained by the proportion (6.7%) of young people reporting use of new psychoactive substances sold in head shops and on line.

Table 4 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/3, 2006/7 and 2010/11

Ecstasy use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.7	5.5	6.9	4.9	7.4	10.1	2.6	3.6	3.7	7.1	9.1	10.9
Last year	1.1	1.2	0.5	1.5	1.8	0.6	0.6	0.6	0.3	2.3	2.4	0.9
Last month	0.3	0.3	0.1	0.6	0.5	0.1	0.0	0.2	0.0	0.6	0.6	0.1

Source: National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011)

The increase in the proportions using any illegal drug at some point in their lives between 2006/7 and 2011/12 was influenced by the fact that drug use in Ireland is a recent phenomenon and the population of lifetime and recent drug users is relatively young. Drug use is measured among adults aged 15–64, and those leaving this age group over the next five years are less likely to have been exposed to drug use than those entering the measurement cohort. The relative stability in last-year use of cannabis and cocaine indicates that the situation with respect to these drugs has stabilised.

When compared to the 19 other countries that completed a general population survey on drug use using the European

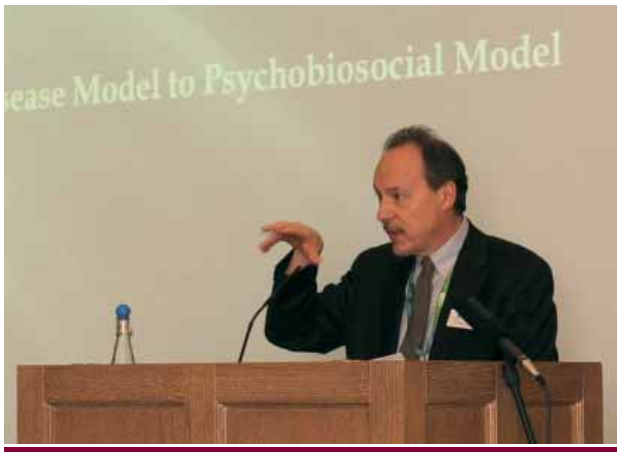
Results from the third general population survey *(continued)*

model questionnaire, Ireland ranks eighth highest for lifetime use of cannabis, fourth for lifetime use of amphetamines, fourth for use of cocaine, second for ecstasy and second for LSD.[2]

(Jean Long)

1. National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011) *Drug use in Ireland and Northern Ireland: first results from the 2010/11Drug Prevalence Survey.* Bulletin 1. Dublin: NACD & PHIRB. www.drugsandalcohol.ie/16450
2. European Monitoring Centre for Drugs and Drug Addiction (2011) *Statistical bulletin 2011*. Accessed 20 November 2011 at www.emcdda.europa.eu/stats11/gps

National Drugs Conference of Ireland 2011



Dr Andrew Tatarsky, a plenary speaker at the conference

The second National Drugs Conference of Ireland took place at the Radisson Blu Hotel in Dublin 8 on 3–4 November 2011. The theme of the conference was 'Drug Interventions: what works?' The packed, two-day programme brought together a wide range of people from the community/voluntary sector as well as from government organisations to share knowledge, expertise and good practice in drug policy and drug service provision in Ireland. Some 275 delegates were in attendance.

Opening the conference, Minister of State **Róisín Shortall** stressed that all drug interventions should have a strong evidence base. She warned that resources would remain tight and that 'we must ensure the limited public funding that is available is used in the most effective and optimum way'. She said that agencies should work together and play a part in implementing the National Substance Misuse Strategy.

Ms Shortall said the response to drug addiction needed to be client-centred and should ultimately enable service users to address their health, social, housing and employment needs. She pointed to family involvement as an important tool in fighting addiction, saying it increased the likelihood of successful outcomes and decreased the chances of relapse. Ms Shortall stated that she would like to see clients move more quickly through methadone programmes and into recovery. She said she was looking for information from the HSE on the length of time people were in methadone treatment and that she wanted more GPs involved in treatment. She also stated that she was pleased to have signed an order classifying 60 psychoactive substances sold in head shops as controlled substances.

Referring to alcohol, the minister said that alcohol has become 'dirt cheap' and that, in many cases, young people were not able to handle the amount of alcohol they could now afford. She spoke of the need to reduce alcohol consumption and said that the Governement will examine recommendations on pricing and availability including minimum pricing.

Over the two days there were 19 Irish and international plenary speakers, as well as 26 speakers across parallel sessions. This article can give only a brief overview of the proceedings. Further information and a number of the presentations can be accessed at www.inef.ie.

Various organisations and researchers took the opportunity of launching/presenting their recent work at the conference. **Siobhan Cafferty** from Pavee Point launched *Good practice guidelines for drug and alcohol services for Travellers*, which can be accessed at www.drugsandalcohol.ie/16232. **Marie Claire van Hout** and **Tim Bingham** launched *Holding pattern: an exploratory study of the lived experiences of those on methadone maintenance in Dublin North East*, which can be accessed at www.drugsandalcohol.ie/16250. **Robert O'Driscoll** and **Miriam Keogh** presented their research *Inter-agency practice and outcomes for teenagers with addiction and social services*. **Gary Broderick** launched *Reduce the use 2*, a manual for professionals working with polydrug users developed by the SAOL Project and available at www.drugsandalcohol.ie/16230. **Aoife Dermody** launched two protocols on behalf of Progression Routes Initiative – *Community detoxification protocols: benzodiazepines* and *Community detoxification protocols: methadone*. Both of these reports are available at www.drugsandalcohol.ie.

Dr Joao Goulao spoke about the impact of drug policies in Portugal, in particular, the introduction of policy in 2001 that led to the decriminalisation of drug use. Under this policy, people who are caught in possession of drugs for personal use are dealt with by a commission comprising a legal expert, a health professional and a social worker. He stated that decriminalisation has not had a negative impact and that drug addicts are now seen as sick people with treatment needs rather than delinquents.

Dr Paolo Deluca introduced the delegates to the Recreational Drugs European Network (ReDNet) project, a multi-site implementation project with the aim of improving the level of information available to young people (aged 16–24) and professionals on the effects of new recreational drugs and the potential health risks associated with their use. This is available at www.rednetproject.eu. On a similar topic, **Ann Campbell** described her research findings on adolescents' experiences of psychoactive substances in Ireland.

National Drugs Conference 2011 *(continued)*

RADE (recovery through art, drama and education) participants gave the delegates an enjoyable ten minutes as they performed their own drama, *Get stoned*, which challenged the stereotypical views of drug users, law enforcement, the community and politicians regarding drug use. **Martin Woods** spoke about the link between drug killing in Mexico, money laundering in London and whistle blowing. He was followed by **Johnny Connolly**, who described drug markets in Ireland.

Dr Tom McLellan spoke of the scope of substance use in the US, where there are 13,200 treatment programs. He queried the current approach to treatment, saying that it needs to become more patient-centred and more integrated into healthcare. **Damon Barrett** described drug policy from a human rights perspective and said that more work needs to be done in this area. **Dr Jenny Scott** gave an overview of the pharmacist's role within a community pharmacy needle exchange in the UK, after which **Denis O'Driscoll** gave the delegates an update on a similar scheme in Ireland. He said that 42 pharmacies will be involved in the scheme by the end of 2011, with a further 30 becoming involved in 2012. **Marion Rackard** outlined the National Rehabilitation Framework Training programme, which will involve 10 pilot sites, five protocols to establish national standards and three key modules.

(Deirdre Mongan and Mairea Nelson)

What are the Minister's priorities?

On 22 September 2011 Róisín Shortall TD, Minister of State at the Department of Health with responsibility for Primary Care and the Drugs Issue, appeared before the Joint Committee on Health and Children to talk about illegal drug use. Below are excerpts from the Minister's responses to the Committee.[1]

Legal highs

… work is well advanced in my Department on the introduction of regulations under the Misuse of Drugs Acts to control a further extensive range of products.

Needle exchange

Approval has recently been granted for the proposed provision of needle exchange services in approximately 65 community pharmacies at various locations outside Dublin, with part funding being provided by the Elton John Aids Foundation. A national liaison pharmacist has been appointed to oversee this programme, the roll-out of which will begin next month. Needle exchange services in Dublin are provided through HSE clinics, and through voluntary sector providers, so this initiative will facilitate broad national coverage.

Methadone treatment

I am concerned about people getting stuck on methadone without having an adequate progression through the system [to a drug-free life]. … We are examining ways of ensuring there is that kind of progression by involving more GPs. I see no reason a large number of drug users' regular GPs cannot provide treatment for their drug problem, just as they treat them for any other health problem they may have. A certain cohort of drug users would be regarded as quite chaotic and would not be suitable for treatment in local GPs' surgeries. Many drug users, however, should be treated by GPs and, therefore, I want to see those GPs' services being expanded. I am working on that at the moment.

Alcohol

I hope to bring forward specific proposals on three key areas of concern, the first of which is pricing. … Personally, I would be very committed to going that route [minimum pricing] if it were legally sound. That is the basis on which we are proceeding to address that problem. … the other key area is the explosion in the number of outlets for alcohol. … Alcohol is not a normal product for sale in a supermarket like food, milk, minerals or whatever. It is a potentially dangerous product and for that reason, it needs to be treated differently to other products. It was a retrograde step to liberalise the licensing laws in the way we did, which opened up the question of availability. … The other area is clearly the availability of alcohol to those under age. … We need to tackle the issue of distance selling … We also need to tackle the question of under age sales and there needs to be greater enforcement of the law in that area. … The third area is the question of those over 18 buying alcohol for those aged 13 or 14 waiting outside. I am not satisfied that there has been adequate enforcement of the law in that area. … I would like to see us being much more vigorous in that regard and there will be proposals on that in the new strategy.

Benzodiazepines

I have decided to take an initiative on the information available to us on persons on medical cards who are prescribed benzodiazepines as well as persons who avail of the community drugs scheme. As the committee will be aware, all of those data are available in the primary care reimbursement centre in Finglas. There are rich data available on exactly what is happening in prescribing for most of the population.

I hope, starting next month, that an in-house team within the PCRS will investigate those figures, look in detail at prescribing patterns in respect of benzodiazepines, and identify problem areas, problem practices, problem GPs in terms of their prescribing patterns and where patterns are out of line with national norms and best international practice. At that point, when we have the data to see the extent of the problem, we will take it to the next step further where that team will meet GPs where there are difficulties, address it at that level and work with those GPs to bring their prescribing patterns into line with best practice.

Treatment waiting times

In the Dublin area, waiting times are approximately one month. That is an improvement but a month is still too long. … I am aiming for two weeks. … Progress is being made in this area. It entails acceptance of new treatment facilities and the recruitment of more GPs.

Education

There are common threads in the profile of those most at risk of using heroin, in particular, such as poverty, family dysfunction and early school leaving. All those factors predispose people to abusing drugs. Education programmes in schools need to tackle the problem of low self-esteem and to provide education and employment opportunities for people as well as making them aware of the dangers of the abuse of alcohol and illicit drugs. Programmes are in place in schools and a group within the Department of Education and Skills is reviewing them to ensure they are up to date and relevant to where young people find themselves.

What are the Minister's priorities *(continued)*

Drugs task forces

I am currently reviewing the role of the drugs task forces in respect of accountability and clarity of their role in terms of oversight of the projects they sponsor. … We need better evaluation to ensure good standards are in place. This will be part of the evaluation to be carried out.

There are real strengths in having this type of local response to the drug problem in areas where there is greatest prevalence. The local drugs task forces are in the 14 most disadvantaged areas, in terms of the greatest use of heroin in particular. The local drug task forces provide a local forum for the community, voluntary sector, statutory agencies and, in many cases, public representatives to work together to address the local problem in a meaningful and constructive way. I am examining the composition of the drugs task forces. I would like to see public representatives playing a greater role in the drugs task forces. …

There is often confusion between groups working under the banner of the drugs task forces and those that are community development projects, partnership companies and so on. It is important to distinguish between the work of the different sectors. There are concerns about various aspects of the different schemes. We are currently examining those to ensure coherence and a better level of accountability in that regard. I would be nervous about tarring all community bodies with the same brush. We need to acknowledge that there is now greater accountability and evaluation in that regard. We must distinguish between those that are good and those that could be much better.

(Compiled by Brigid Pike)

1. Róisín Shortall (2011, 22 September) Illegal drug use: discussion (resumed). Houses of the Oireachtas: Joint Committee on Health and Children. Accessed 1 December 2011 at http://debates.oireachtas.ie/HEJ/2011/09/22/

Drugnet digest

This section contains short summaries of recent reports and other developments of interest.

Minister bans more head shop products

On 1 November 2011 Róisín Shortall TD, Minister of State with responsibility for drugs strategy, approved an Order declaring a further sixty or more new psychoactive substances being sold in head shops or online to be controlled drugs under the Misuse of Drugs Act 1977.

These substances include:

- additional cathinone substances (similar to mephedrone, which was controlled in May 2010)
- naphthylpyrovalerone and related substances (such as the product Pure NRG) further synthetic cannabis-type substances (often sold as smoking mixtures)
- dimethocaine and desethyl dimethocaine (contained in the products Amplified and MindMelt)
- desoxypipradol (found in the legal high product WHACK)
- luorotropacocaine (also found in the legal high product WHACK)
- aminotetralins and aminoindans (contained in the legal high product Pink Champagne)
- bromo-dragonFLY
- salvinorin A (found in the plant Salvia divinorum)
- mitragynine and 7-hydroxymitragynine (found in the plant known as kratom).

www.dohc.ie/legislation/statutory_instruments/pdf/si20110551.pdf

Coolmine Therapeutic Community annual report 2010

The Coolmine Therapeutic Community annual report for 2010 contains information relating to the organisational highlights, statistics, past client stories, partnerships and fundraising, and financial statements (www.coolmine.ie/about-us/downloads).

According to the report, CTC is continuing to build capacity to facilitate detoxification and has recruited a clinical nurse specialist. There was an increase in the number of referrals and admissions of women with young children to the residential programme at Ashleigh House. The refurbishment of 19 Lord Edward Street was completed, and stabilisation and drug-free day programmes moved back there. Coolmine staff were trained in the community reinforcement approach (CRA) to working with individuals and their families. A training and education programme was established at Coolmine which is managed by the career guidance counsellor.

In 2010 Coolmine worked with 1,161 people:

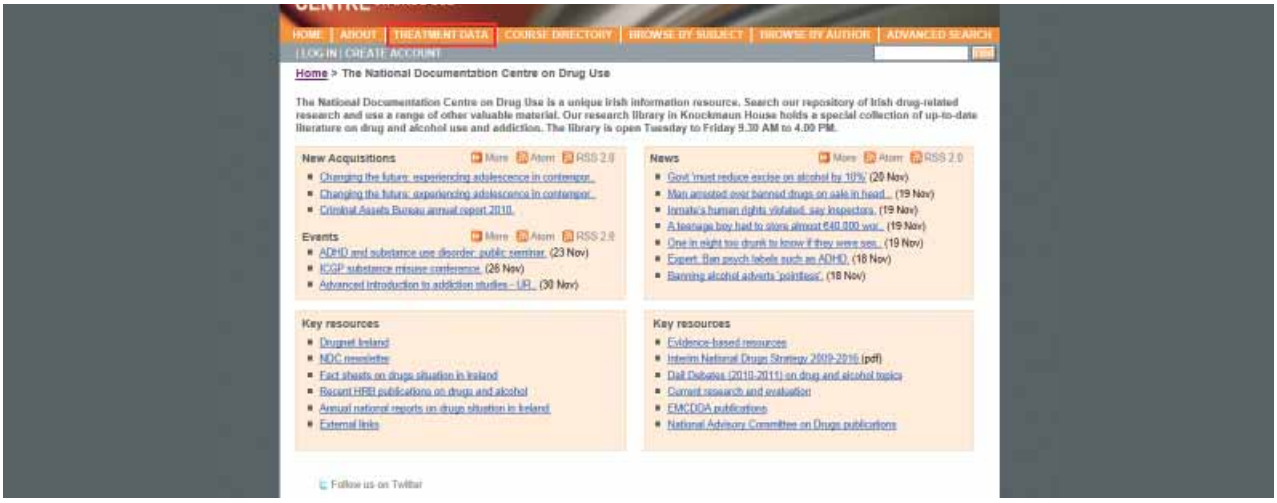
- The Outreach team worked with 822 clients spanning both residential and day programmes.
- The Drug Free Day Programme worked with 51 clients.
- 50 clients accessed the Welcome Programme.
- The Women's Residential Service at Ashleigh House admitted 42 women, of whom five had their children permanently on site. Seven women completed a detoxification programme.
- The Men's Residential Service at Coolmine Lodge admitted 76 men, of whom 13 completed a detoxification programme.
- Family Support Services provided supports to 120 family members.
- 73 clients secured housing, including emergency, transitional, private, step-down and supported long-term accommodation.
- 92 clients were supported by the career guidance service.

The priorities for Coolmine in 2011 include a review of the strategic plan, maintaining staffing levels, the commencement of a longitudinal research programme and the continued integration of evidence-based practices within the Community.

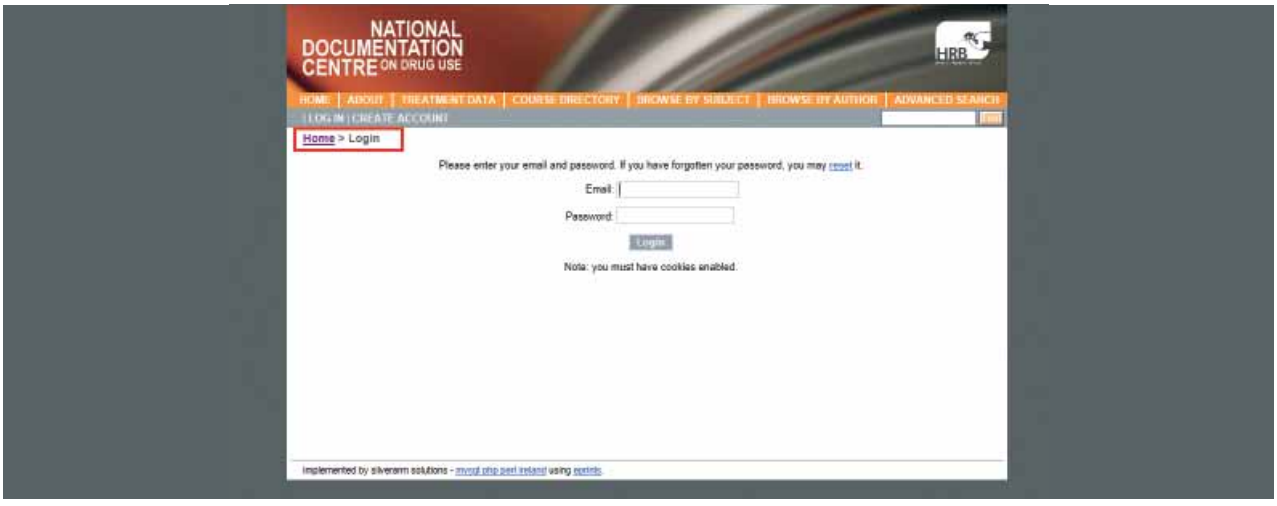
(Contributors Jean Long and Anne Marie Carew)

Latest NDTRS drug treatment data now available on line

New drug treatment data for 2009 and 2010 from the National Drug Treatment Reporting System (NDTRS) are now available on line through the National Documentation Centre on Drug Use (NDC) website at www.drugsandalcohol.ie. The addition of this new data means that there are now seven years of drug and alcohol treament data available through the NDTRS interactive tables. Once on the site, click on the TREATMENT DATA tab.



You will be asked to log in. If you do not already have an NDC account, you can create one now.



You will be asked to accept a number of terms and conditions of use. This is needed to protect the identity of clients included in the NDTRS. We also ask that the NDTRS is acknowledged when data from the tables are used in a publication or presentation, and that the NDC receives copies of any publication in which these data are used.

When interpreting the data, it should also be remembered that each NDTRS record relates to a treatment episode (a case) and not to a person, as there is currently no unique health identifier. This means that the same person could be counted more than once in the reporting year if they had more than one treatment episode in that year.

You can run different analyses on the treatment data based on up to eight different types of drug, including alcohol, in various combinations. The variables available for analysis include year, age group, gender and geographical region of residence (county, HSE region, LHO, regional or local drugs task force area). Your analysis can then be exported into Excel.

For further information contact the NDC at 01 2345 175 or at ndc@hrb.ie

(Suzi Lyons and Brian Galvin)

Drugnet Ireland 10 years on: what have we learned?

The Health Research Board published the first issue of *Drugnet Ireland* in 2001. The 40 issues published since then have, we hope, contributed to our readers' understanding of the scientific, social, political, educational and economic issues which impact on the drugs situation in Ireland. Drugs policy, from the formulation of government strategic objectives to the choice of interventions made by service providers, is shaped by information which is often concise and pertinent but sometimes contradictory and impenetrable. It has been our task to alert you to new information, to make it understandable and to explain its relevance. We will continue to contribute to public understanding of drug-related issues to inform an increasingly sophisticated and rigorous public debate, and present evidence needed by practitioners and policy makers in an accessible form.

The first *Drugnet Ireland* was published shortly before the launch of a drugs strategy committed to the development of the evidence base on drugs issues and pursuance of policies based on this knowledge. In this article we reflect on what has actually been learned over the past 10 years and what changes in research practice and output have made a difference. We look forward to your continued support in 2012.

Drug prevalence among the general and school-aged populations

Drug prevalence surveys of the general and school-aged populations are important sources of information on patterns of drug use, and, when repeated, reveal changes over time. These surveys increase understanding of drug use, which, in turn, help in the formulation and evaluation of drug policies. They also enable informed international comparisons, provided countries conduct surveys in a comparable manner. There are two key drug prevalence surveys undertaken in Ireland.

The All-Ireland Drug Prevalence Survey, first administered in 2002/3 and twice subsequently (2006/7 and 2010/11), seeks to obtain prevalence rates for the more commonly used illegal drugs, such as cannabis, ecstasy, cocaine and amphetamines, on a lifetime (ever used), last year (recent use), and last month (current use) basis. Similar prevalence questions are also asked of alcohol, tobacco, and other drugs such as sedatives, tranquillisers and anti-depressants. Attitudinal and demographic information is also sought from respondents. In the most recent survey, measures to assess the prevalence of dependence on cannabis were included.

The questionnaires are administered through face-to-face interviews with respondents aged between 15 and 64 normally resident in households in Ireland and Northern Ireland. Thus, persons outside these age ranges, or who do not normally reside in private households, are not included in the survey. This approach excludes those living in institutions (for example, prisons, hostels). Therefore this type of survey is not a good measure of drug use among marginalised populations, nor of drugs that are more commonly used among such populations, such as crack cocaine or heroin; different research approaches are required among such groups. Bulletins reporting the findings of all three iterations have been published and can be found at www.nacd.ie/publications/index.html

The European School Survey Project on Alcohol and Other Drugs (ESPAD) is a collaborative effort of independent research teams in about 40 European countries, including Ireland. Data on alcohol and illicit drug use among 15–16-year-olds have been collected every four years since 1995, using a standardised method and a common questionnaire. Data were collected for the fifth iteration of ESPAD in spring 2011 and the survey findings will be published in 2012. The rationale for the survey is that school students are easily accessible and are at an age when onset of substance use is likely to occur. By definition, early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented. The ESPAD survey reports are available at www.espad.org/espad-reports

Problem drug use

'Problem drug use' is defined by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as 'injecting drug use or long duration/regular use of opioids, cocaine and/or amphetamines'. This definition includes regular or long-term use of prescribed opioids such as methadone but does not include their rare or irregular use or the use of other drugs, such as ecstasy or cannabis. Currently, estimates of problem drug use in Ireland are limited to opioid use, using three-source capture–recapture methods for 2001, 2002 and 2006 (Kelly *et al.* 2003, 2009); owing to methodological limitations, the 2006 estimated figures are likely to be inflated. In 2010 the National Advisory Committee on Drugs (NACD) commissioned the Centre for Drug Misuse Research at the University of Glasgow to examine the methods and data sources available to estimate the prevalence of problem opiate and cocaine use. The researchers recommend that the best national estimate of problem opiate use can be obtained using four national datasets and that the capture–recapture estimate begin at county level and build to national level. This estimate would be validated using the multiplier method and multiple indicator method.

Drug-related infectious diseases

Problematic drug use can be associated with a number of other health conditions or lead to a range of health consequences, including drug-related infectious diseases. This key indicator collects data on the incidence and prevalence of, primarily, HIV, hepatitis C and hepatitis B infection among people who inject drugs. The incidence data are collected through routine surveillance of newly diagnosed cases which identifies injecting drug use as a risk factor, or through cohort studies. In Ireland the Health Protection Surveillance Centre (HPSC) has recorded new cases of HIV among injecting drug users since 1985, and of hepatitis B since 2004 and hepatitis C since 2007. Reporting to the HPSC of risk factors for HIV cases and hepatitis C cases is high, but for hepatitis B is much lower than desirable. The prevalence of HIV, hepatitis B and hepatitis C among injecting drug users has not been reported since 2002.

Early warning system and emerging trends

Established in 2001, the Early Warning and Emerging Trends Sub-Committee of the NACD advises the Irish government on emerging drug trends or practices and their consequences. The members of the committee are recruited from a wide range of government departments, professional

Drugnet Ireland 10 years on *(continued)*

disciplines and services, including police and customs, human, chemical and forensic toxicology, pharmacology and pharmaceutical science, emergency medicine, drug treatment, harm reduction, public information and research, including the EMCDDA's national focal point in Ireland, which is located within the Health Research Board.

Treatment

In the early years of *Drugnet Ireland* one of the dominating issues in drug treatment was problem opiate use and the provision of opiate substitution treatment.

The ROSIE study, commissioned by the NACD, was Ireland's first national, prospective, longitudinal drug treatment outcome study. The main objective was to 'evaluate the effectiveness of treatment and other intervention strategies for opiate use in Ireland'. In 2003/04, 404 opiate users who entered treatment were recruited and, of these, 289 (72%) completed the follow-up questionnaires one year and three years later. Despite methodological limitations, the overall results showed positive outcomes for opiate users in treatment over the three-year period, including a reduction in the use, number and amount of drugs; an increase in abstinence; a decrease in the proportion of participants who were homeless; and an increase in the proportion who were in employment over the three-year period. Since the study was completed its results have been used to inform a number of strategies, in addition to providing a wide range of additional information through numerous journal articles. The reports on the ROSIE study are available at www.nacd.ie

In response to the heroin problem in Dublin and, in particular, concern about the spread of HIV, the first Irish methadone treatment protocol (MTP) was published in 1998. The protocol has been reviewed internally (Methadone Prescribing Implementation Committee 2005) and externally (Farrell and Barry 2010). The external review concluded that the original protocol had achieved its aims, particularly in regulating and improving poor prescribing and quality practices. These improvements occurred against a background of increasing numbers receiving methadone and increasing availability of methadone treatment. The number of continuous care clients attending methadone treatment, as recorded in the Central Treatment List has steadily increased, from 3,681 in 1998 to 8,727 in 2010. The numbers of clients attending Level 1 GPs and receiving methadone in prison have also increased over the same period.

The external review of the MTP also recommended that buprenorphine/naloxone should be routinely available as a treatment option, to which end the review was entitled *The introduction of the opioid treatment protocol*. Other recommendations included expanding clinical governance and audit, increasing the number of Level 2 GPs, reviewing the current urinalysis regime, creating guidelines of treatment in Garda stations, and improving data collection and analysis.

Drug-related deaths

An issue associated with problem opiate use is drug-related deaths. For several years prior to 2005 a theory had been in circulation that the number of drug-related deaths in Ireland was being under-recorded. This theory was supported by a number of small studies, one in particular (Byrne 2001, 2002) which found that annual numbers of opiate-related deaths recorded by the Dublin coroners were consistently higher than those recorded in the General Mortality Register. In addition, families of substance users in Dublin, through the auspices of the Family Support Network, had been calling for an accurate measurement of the extent of premature death among drug users.

Action 67 of the 2001–2008 National Drugs Strategy called for the development of a system for recording drug-related deaths and deaths among drug users to enable the State and its agencies to respond in a timely manner, with accurate data. In compliance with this action, the Irish National Drug-Related Deaths Index (NDRDI) was established in September 2005. The strength of the NDRDI is that it records data from four sources – the Coroner Service, the Hospital In-Patient Enquiry scheme (HIPE), the Central Treatment List (CTL), and the General Mortality Register (GMR) – in order to ensure that the database is complete and accurate. To date, the NDRDI has shown that the number and extent of drug-related deaths in Ireland is increasing, and the data have been used to inform policies at both national and European levels. Reports on the data collected in the NDRDI are available at www.hrb.ie

Problem alcohol use

One issue that has come to the fore in recent years is the extent, and effects, of problem alcohol use among the Irish population. The National Drug Treatment Reporting System (NDTRS), established in 1990, was originally designed to record problem drug use and only recorded problematic use of alcohol in cases where it was an additional problem substance. In 2004, the remit of the NDTRS was extended to include cases who reported alcohol as their main or only problem drug. These data provide valuable information and improve our understanding of the extent of the problem, the characteristics of those seeking treatment, and trends in treatment over time. Reports on the data collected in the NDTRS are available at www.hrb.ie

The remit of the NDRDI was also extended, and the index has now retrospectively collected information on alcohol-related poisoning deaths and deaths among those who were alcohol dependent, which, together with the treatment data, increases our understanding of the burden of problem alcohol use in Ireland today. In the future, these databases will allow us to measure the impact of any national policy changes on alcohol-related harm in the Irish population.

Drug prevention

Research on risk and protective factors

In one of the first reviews of research on the prevention of drug use published in Ireland, Morgan (2001) summarised the factors that increase the risk of substance use among young people. He identified a number theoretical categories and the context in which the risk factors in these categories arose, including the individual's interactions with family, peers, schools and communities. A number of these categories relate to the social and interpersonal sphere, culture or attitudes that young people experience in their immediate environments.

- The *lack of commitment and social attachment* category emphasises the risks associated with deviant impulses which are not held in check when bonds to society, families, schools and belief systems are weakened.
- The *social cognitive learning theory* category refers to the risks associated with young people's acquisition of their beliefs and behaviours from significant others, such as parents, peers and media celebrities.
- The *family interaction theory* category underlines the risk of maladjustment when a young person's parents fail to exhibit conventional values or norms or provide affection or discipline.

Drugnet Ireland 10 years on *(continued)*

- The *communal risk factors* category highlights how young people are disincentivised to commit to conventional norms and society when communities are disorganised and crime and unemployment are common.

Some theoretical categories emphasise those intrapersonal characteristics and biological predispositions which increase risk.

- The *biological models of vulnerability* category stresses genetic susceptibility and inherited characteristics.
- The *self-derogation and substance use* category explains how negative evaluations, by self and others, result in poor self-esteem and greater risk.
- The *problem behaviour theory* category focuses on the behaviour itself rather than on causative factors. It demonstrates how one form of problem behaviour, such as rebelliousness, is associated with other types of problem behaviour.

A recent study by Haase and Pratschke (2010) examined the association between a number of risk factors and substance use among a group of early school leavers and a group of school attendees. The findings aligned with several of the theoretical categories identified by Morgan. For example, Haase and Pratschke found evidence of family and peer influence on young people's behaviours, including both risk and protective factors, which was consistent with both social cognitive learning theory and family interaction theory. They also found evidence consistent with problem behaviour theory, e.g. aggressive behaviour or 'acting-out' and substance use, and strong interactions between the use of different substances. The connection between low self-concept or self-esteem and substance use posited by self-derogation and substance use theory was demonstrated by the increased likelihood of smoking cigarettes among both early school leavers and school attendees.

Universal prevention in schools

Research done by young people from the Dáil na nÓg Council for the Office of the Minister for Children and Youth Affairs (2010) on the experience of post-primary school students receiving Social Personal and Health Education (SPHE) found that 83% indicated that alcohol, drug and solvent use was the most emphasised theme in the SPHE syllabus. The study identified a number of benefits from participating in the SPHE programme: learning how to make decisions and the chance to discuss interesting subjects were regarded as benefits by more than half the participants; nearly half reported improved self-respect and improved emotional and physical health and well-being, while slightly fewer had developed personal and social skills and had improved mental health and well-being.

A study of the contribution of the SPHE curriculum to the experience of junior cycle students and to the junior cycle curriculum (Nic Gabhainn ***et al***. 2007) found that it contributes positively to students' attitudes to health, especially in their future lives. SPHE helps students to think about and discuss health issues relevant to their age group; it also provides opportunities to develop personal and social skills.

Selective prevention in schools

Smyth and McCoy (2009) undertook interviews with parents, children and principals from DEIS (Delivering Equality of Opportunity in Schools) schools, and with key professionals working in a range of educational bodies and statutory organisations and a national postal survey of school principals. The DEIS programme is a targeted intervention delivered in communities that have been identified as having higher than average scores on a number of indices used to assess the extent of disadvantage. This targeted approach can in theory deal with problems more directly than the universal approach. However, the evidence in the report indicated that the problems faced by children attending DEIS schools were so great in number and intensity that the number of families that might benefit from the DEIS programme could be quite small.

Social exclusion and social reintegration of drug users

Employment and vocational education

Research showed a fall between 2001 and 2006 in the percentage of treatment contacts in employment, despite unprecedented economic growth in the country over this period. Two separate reviews of measures taken to improve the employability of recovering drug users through the FÁS Special Community Employment scheme concluded that the scheme was less focused on improving employability and more inclined to operate in a crisis management mode by providing generic support to recovering drug users. The Bridge-to-Workplace, an inter-agency initiative developed to help recovering drug users return to education or secure work placement in the labour market, reported that between August 2005 and December 2006 over half of participants had completed or were engaged in a work placement.

Homelessness and drug use

The evidence base on the association between homelessness and drug use in Ireland improved considerably during the last decade. In particular, the factors that lead some young people into homelessness have been documented in a number of studies. Studies with homeless young people in Dublin and in Cork (Mayock and Vekic 2006; Mayock and Carr 2008) reported that being in state care, experiencing abusive family situations and developing problem behaviours constituted their pathways into homelessness; once homeless, their substance abuse often exacerbated their experience and led to episodes of insecure accommodation and engagement in high-risk behaviours. Follow-up interviews with the young people in Dublin showed that young people who maintained supportive contact with their families were able to access treatment and make the transition to supportive living conditions. On the other hand, young people with weak family ties and poor education were more likely to remain trapped in homelessness and substance misuse. The legacy of becoming trapped in homelessness was vividly captured in a recent snapshot study of homeless adults using the services of the Simon Communities of Ireland (2010): study participants reported high levels and different combinations of alcohol and illicit drug use; physical and mental health problems were also prominent among these people and many had spent long periods in homelessness.

Drugs and crime, drug markets and supply reduction

The National Drugs Strategy 2001–2008 and the National Drugs Strategy (interim) 2009–2016 both sought to address the harm caused to individuals and society by drug misuse through a concerted focus on supply reduction, prevention, treatment, rehabilitation and research. The research pillar of the two strategies has sought to eliminate gaps in knowledge so as to ensure that policy is evidence based.

Although the link between drugs and crime has been firmly established in the public consciousness in Ireland, there has been little sustained examination of the precise nature of this link. Murphy (in O'Mahony 2002) suggests that, in Ireland, 'the notion of a definite causal connection between drugs and crime is assumed rather than examined' (p. 202).

Drugnet Ireland 10 years on *(continued)*

The primary focus of research in this area has been on examining the economic motivation model of drug-related crime, which emphasises the way in which drug dependency amplifies offending behaviour, particularly in relation to property crime and other crimes such as prostitution. The economic model also highlights the way in which the control of heroin use through closely supervised treatment can lead to a reduction in both drug use and crime. The NACD ROSIE study, mentioned in a previous section, has provided strong evidence that treatment reduces the level of crime.

Other aspects of the drugs–crime nexus remain under-researched – for example, the links between illicit drug use and driving offences, alcohol use or illicit drug use and violent crime, polydrug use and offending, and drug-use, drug-related crime and gender.

Another aspect of drug-related crime highlighted in the literature is 'systemic crime', i.e., crime associated with the illicit drug market. Knowledge about how the illicit drug market operates is an important prerequisite for effective interventions and responses to it. Although the issue of drug-related 'gangland' violence has received a great deal of media attention and has been the subject of numerous journalistic exposés, until recently Ireland's illicit drug markets have not been the subject of any in-depth research and analysis. A recent study on Dublin's crack cocaine market (Connolly *et al.* 2008) and a forthcoming national study published by the NACD and the HRB (Connolly *et al.*, in press) have begun to address this gap. Studies of illicit drug markets are, by their very nature, difficult to conduct. They require researchers to negotiate access to participants in illicit drug markets, both those involved in the production and distribution of drugs and professionals responding to them. They also require the regular compilation of key data sources such as drug seizures, drug prices and drug purity analysis for example.

The last 10 years have also seen a significant intensification in the response of law enforcement agencies to drug-related crime. The Garda National Drugs Unit was established in 1994, and a broad range of legislative provisions has been introduced, including the establishment of the Criminal Assets Bureau, changes to Garda detention and investigation powers, and to the laws on bail and, more recently, legislation tackling organised crime. The emergence of a number of local community policing partnerships in Dublin has also been a positive development, with a commitment in the 2009–2016 drugs strategy to establish similar fora in all local drugs task force areas.

Drug law enforcement activities may have contributed to the relative containment of illicit drug use, and the authorities have had some success in disrupting drug markets and dismantling organised crime groups. However, there is little evidence in Ireland or internationally that such strategies have halted the expansion of the illicit drug market or reduced the criminal activities associated with it for any sustained period of time. Indeed, the consistent demand for illicit drugs often ensures that the removal of one drug trafficker creates a vacuum which is inevitably filled by another.

A recent international review of evidence-based drug policy (Babor *et al.* 2010) reached the stark conclusion that 'there is virtually no scientific research to guide the improvement of supply control and law enforcement efforts… Independent of how strongly a policy maker values law enforcement and supply control as policy tools, it is difficult to understand why policymakers would not want their policies to be based on good quality evidence. The lack of careful study thus continues to pose a major barrier to applying these policies effectively' (p. 258).

Finally, with regard to penal policy, in his seminal study, *Mountjoy prisoners: a sociological and criminological profile* (1997), Paul O'Mahony found that 63% of prisoners had a serious dependency on a 'hard drug', the average age of first imprisonment was just under 19 years, and there were high rates of recidivism, with prisoners having served an average of ten prison sentences. Fifty-six per cent of the prison population came from six areas in Dublin that were characterised by severe levels of socio-economic deprivation and chronic unemployment. The majority still lived with their parents or other relatives, were from large and often broken families, with 80% having left school before the legal minimum age of 16, and 88% of prisoners having been unemployed prior to their imprisonment. A more recent study on prison recidivism (O'Donnell ***et al***. 2007) has confirmed that the general profile of the Irish prison population remains largely unchanged. Although health services for dependent drug users in Irish prisons have improved significantly in the past ten years, such services are often provided in overcrowded conditions as the numbers in prison have increased by almost 100% in the past 14 years.

National policy framework

Notable developments in Ireland's National Drugs Strategy (NDS) since 2001 have included the expansion of the four pillars to include rehabilitation alongside treatment and harm reduction, and recognition of the role of families in tackling the drugs problem. These developments happened on foot of the mid-term review of the first NDS in 2004/5 and the review at the expiry of this same NDS in 2008. While the first NDS included an action calling for a mid-term review, the second NDS, covering 2009–2016, does not include any actions calling for either a review at the mid-way point, in 2012, or an evaluation when the strategy expires in 2016.

The top drug-related policy priority for the government currently is how to combine drug policy with alcohol policy, responsibility for both of which rests with the Department of Health. As well as the growing body of research evidence highlighting the problematic aspects of alcohol use in Ireland, noted in a previous section, several regional drugs task forces, in their first strategic and/or action plans completed in 2005, acknowledged the problems associated with alcohol misuse in their areas and included specific responses in their plans. Public consultations on the NDS have also routinely raised the issue of problem alcohol use. An announcement on the preferred approach to combining the policies was expected as this issue of *Drugnet Ireland* went to press.

Ever since a recommendation by the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996), Ireland's drugs policy and strategy have been located within the wider policy context of social inclusion. As a result, successive national anti-poverty strategies, social partnership agreements and national development plans have all impacted on the design and delivery of drug policies. The adoption of a lifecycle framework for social policy, following publication of the National Economic and Social Council (NESC) report *The developmental welfare state* in 2005, has had implications not only for the delivery of drug-related policies but also for drug-related research. Longitudinal studies are now required in order to assess accurately the impact of policies on individuals over the course of their entire lifetime.

Drugnet Ireland 10 years on *(continued)*

Following the reorganisation of drug-related policy functions in early 2011, the new government's view on the wider policy context of the drugs issue has become less clear. Prior to the February election, responsibility for drugs policy was located in the same government department as community and local development, equality and social inclusion policy, suggesting a common goal or shared aspiration among all these policy domains. The new government has separated these four policy areas and assigned them to four different government departments. How the Department of Health will co-ordinate implementation of the national drugs strategy remains to be seen.

Over the past decade Ireland's drug and alcohol policy frameworks have been the focus of academic research and critical commentary. Since the publication of Shane Butler's *Alcohol, drugs and health promotion in modern Ireland* (2002), there has been a steady trickle of studies around the need to move Ireland's policy responses away from concepts such as the 'disease model' of alcoholism or the 'war on drugs' to exploring how a health promotion, or more recently, a population health, model might be applied (Butler and Mayock 2005; O'Shea 2007; Cullen 2011; Randall 2011). In *The Irish war on drugs: the seductive folly of prohibition* (2008), criminologist Paul O'Mahony argued that Irish society would make substantial gains from accepting the libertarian view that there is a right to use drugs so long as others' rights are not infringed. He suggested that a non-coercive harm reduction approach could eliminate many of the ill-effects of prohibition and create a positive attitudinal dynamic that lowers the irresponsible and destructive use of drugs.

The policy process itself has also been the focus of attention. Brigid Pike (2008) reviewed Ireland's first national drugs strategy as a 'policy instrument', in order to gain insights into how structural elements such as the hierarchy of aims and objectives or governance arrangements might influence the strategic outcomes. She highlighted underlying tensions in the areas of goal-setting, information gathering, co-ordination, and responding to changing circumstances and needs, which have the potential to adversely affect outcomes. In a study of the research/policy interface and the extent to which drug policy in Ireland might be deemed to be a rational, evidence-based process, Niamh Randall (2011) concluded that drug-related policy making in Ireland is unlikely ever to attain the degree of rationality suggested by the managerialist rhetoric of the national drugs strategy.

(Johnny Connolly, Brian Galvin, Martin Keane, Jean Long, Suzi Lyons, Brigid Pike)

The bibliography for this article is included in the electronic version of this issue and in the article as posted on the National Documentation Centre website, both available at www.drugsandalcohol.ie

Service providers accredited in Community Reinforcement Approach

On Friday 7 October 2011, 83 front-line service providers working in the substance use field received accreditation as trained practitioners in the delivery of a number of evidence-based positive reinforcement approaches that address substance use: 52 received accreditation in the Community Reinforcement Approach (CRA), 19 in the Adolescent Community Reinforcement Approach (ACRA) and 12 in Community Reinforcement and Family Training (CRAFT).

The graduation event, held in the Grand Hotel Malahide, was the culmination of a two-year implementation plan by Blanchardstown Local Drugs Task Force to introduce the use of the CRA model. The plan involved training nearly 200 frontline workers from a range of sectors, disciplines and agencies across the task force area and some regional areas and was funded by the HSE Social Inclusion Unit. The graduates all completed an intensive process which involved training, supervision groups and assessment, by external coders in the US, of recorded CRA sessions with clients.

Dr Bob Meyers with some of those who chaired trainee accreditation groups (l to r): Yvonne Booth, Sean Foy, Suzanne White, Gemma Collins, James Kelly, Catherine Meleady, Kevin Ducray and David Madden.

Chairman of the task force, Mr Tony Geoghegan, opened the event and spoke of the task force's commitment to 'supporting agencies in the areas under the task force to use evidence-based approaches to respond to the needs of clients [and] to empower workers in agencies by providing them with accredited training'. Brid Walsh, co-ordinator of the task force, thanked her team for their hard work in implementing the plan to bring CRA to the task force areas and for organising the graduation event, giving a special mention to Ciara Jubani and Louise McCulloch. Ms Walsh said that the people who had been trained and accredited 'had bought into the positive reinforcement approach, as it was about providing a quality service to clients'. Dr Robert Meyers from the US, who was instrumental in building on earlier versions of the approaches and who trained all the accredited participants, remarked on the enthusiasm, dedication and professionalism displayed by all participants during their training and assessment and congratulated them on their achievements. He observed that they were the largest group to have been trained and accredited in the CRA approach anywhere in the world.

An article by Dr Meyers and colleagues[1] describes CRA as 'a cognitive-behavioral intervention that was founded on the belief that environmental contingencies play a critical role in encouraging or discouraging substance abuse. …[the approach uses] community (i.e., familial, social, recreational and occupational) reinforcers to support change in an individual's drinking or drug using behaviors.'

(Martin Keane)

1. Meyers RJ, Villanueva M and Smith JE (2005) The Community Reinforcement Approach: history and new directions. *Journal of Cognitive Psychotherapy*, 19(3): 247–260.

Review of motivational interviewing in addressing substance abuse

Motivational interviewing (MI) is acknowledged in the National Drugs Strategy (NDS) as an effective evidence-based intervention in the treatment of alcohol and stimulant abuse. The NDS also promotes the training and up-skilling of addiction counsellors to deliver MI to clients.

Smedslund and colleagues[1] undertook a systematic review of randomised controlled trials that assessed the effectiveness of MI in reducing drug use, improving retention in treatment and readiness to change, and reducing the number of repeat criminal convictions. The authors provide a useful description of how MI is intended to work, and describe four key strategies that addiction counsellors employ:

- The counsellor expresses empathy with the client; they try to see the world through the eyes of the client.
- The counsellor supports self-efficacy; they give responsibility to the client for choosing and undertaking actions to change.
- The counsellor rolls with resistance; they do not fight with client's resistance or ambivalence to change, they continue to assist clients to further explore statements that signal ambivalence.
- The counsellor develops discrepancy; they assist the client to perceive a discrepancy between their current behaviour and their future goals and aspirations.

Fifty-nine trials undertaken between 1993 and 2010 covering 13,342 participants were included in the review; 57 were RCTs and two were quasi-RCTs. Twenty-nine trials involved alcohol abusers, eight involved cannabis abusers, four involved cocaine abusers, and 18 involved abusers of more than one substance. Only trials that included video or sound recordings of the intervention being delivered were included, to ensure that the intervention provided was in fact MI.

The authors found that people who received MI reduced their use of alcohol and drugs more than people who did not receive any treatment. The effect was strongest immediately following treatment and became progressively weaker at short-term (up to five months), medium-term (6–11 months) and long-term follow-up (12 months or more). The authors conclude that delivering MI to reduce substance abuse is more effective than doing nothing. Compared with interventions such as giving feedback on assessments or other types of psychotherapy, MI did not prove superior or inferior in reducing substance abuse. There were insufficient data in the trials to reach conclusions about the effects of MI on retention in treatment, readiness to change, or repeat convictions. The authors signal concern about the quality of the research available on the effectiveness of MI and call for a degree of caution to be applied when reading their conclusions in this review.

(Martin Keane)

1. Smedslund G, Berg RC, Hammerstrøm KT, Steiro A, Leiknes KA, Dahl HM *et al.* (2011) Motivational interviewing for substance abuse. *Cochrane Database of Systematic Reviews*. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008063.pub2/abstract

Employment and drug use: an emerging evidence base

Bauld *et al.* (2010) undertook a study on behalf of the Department of Work and Pensions (UK) to examine the issues surrounding benefit uptake by individuals who use illicit drugs, particularly heroin and/or crack cocaine. The study also explored the wider context of education, training and employment for drug users, as well as the role of treatment. The study included two components: a comprehensive but non-systematic review of relevant literature and semi-structured interviews with 75 individuals, 54 male and 21 female, who were current or recent users of drug treatment services in five separate case study areas in the UK. Ten service providers from the five locations were also interviewed. This article will present the findings from the interviews with the 75 individuals.

Education and training profile

Most of the people interviewed had left school with few qualifications. Their early-school experiences included school expulsion, episodes of truancy, being the victim of bullying and dealing with dyslexia. Several reported returning to vocational training when they left school and some managed to achieve vocational qualifications. However, most remained poorly qualified for the labour market and lacked many of the skills sought by employers. Some felt their employment prospects were restricted by having had a poor education and the fact that they had few skills and qualifications.

Employment and benefits history

Most of the people interviewed were not in paid legal employment but many were involved in volunteering, with some in drug and alcohol services. Volunteering was perceived as very beneficial in that it provided opportunities to move into employment and assisted with recovery. Volunteering allowed them to test out their ability to work, and also enabled them to give something back to their community and help support others in a similar position.

Most had worked at some point in the past, some for longer periods than others. A small number had advanced work-related knowledge and skills and had secured meaningful employment, while others with few vocational skills were confined to working in unskilled jobs. All interviewees were either currently in receipt of benefits or had received them in the past, these included incapacity benefit, income support and job-seekers allowance.

Barriers to employment

Interviewees were reported to be lacking in self-confidence and coping with poor mental health, including depression and anxiety. Related to their lack of self-confidence was a fear of relapse if they returned to work before they felt ready. They felt incapable of meeting the demands of returning to work and, for some, the idea of job-hunting was a daunting prospect. Some were daunted by the prospect of putting together a CV and attending interviews and trying to

Employment and drug use *(continued)*

account for long gaps in their CV and a lack of references. A common theme among interviewees was their concern that the physical health problems they suffered from, such as multiple sclerosis, back injuries and hepatitis C, might prevent them from finding employment.

They also feared stigmatisation from potential employers because of their history of using drugs; related to this was uncertainly about how employers would deal with their receiving treatment while being employed. Other respondents worried about the side effects of medication compromising their ability to work properly.

Interviewees admitted to involvement in shoplifting, burglary, drug dealing and fraud as a means of obtaining money for drugs. Most admitting having done cash-in-hand work and some had been involved in prostitution.

Future aspirations

Almost all the people interviewed expressed the view that becoming drug free was a higher priority than coming off benefits and getting a job. For many, this involved coming off a methadone prescription. On the other hand, some wanted to start taking methadone so they would be able to move into employment. According to the authors, this illustrates 'just how personal ideas about what constitutes recovery are'.

The barriers to employment articulated by the people interviewed in this study are also to be found in a review of the literature by Cebulla and colleagues (2004). According to a recent report by Drugscope (2010), these barriers are consistently mentioned throughout the literature. In a number of evaluations of vocational training interventions published in Ireland that included the views of service users, similar findings emerged (Lawless and Cox 2000; Bruce 2004; Lawless 2006). This type of consistent coverage of the salient barriers to employment for drug users signals a degree of consensus on what needs to be tackled by interventions if the employability of drug users is to improve.

Conclusion

The research reported on here illustrates the nature of the challenge that faces both service users and providers when trying to improve the employability of people with drug-using histories. However, this is by no means an insurmountable challenge and for many people with drug-using histories, their chances of returning to the labour market can be improved by services that focus on three key areas: personal development, education and quality vocational training, and consistent and effective treatment that leads either to abstinence or to a measure of stability that is meaningful to the client and reproducible over time. It must also be accepted that, for some people with drug using histories, their physical and mental health may be so compromised, that returning to employment may not be a feasible option.

(Martin Keane)

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Lawless K (2006) *Listening and learning: evaluation of Special Community Employment programmes in Dublin North East. Dublin:* Dublin North East Drugs Task Force.

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Update on drug-related deaths and deaths among drug users

National Drug-Related Deaths Index (NDRDI) figures on drug-related deaths and deaths among drug users reported in 2009 are now available on the web.[1] The figures in this update supersede all previously published figures. Similarly, figures for 2009 will be revised when data relating to new cases becomes available.

For the first time, alcohol only poisonings are included in this analysis. Previously these cases have been reported separately.

In the six-year period 2004–2009 a total of 3,334 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 2,015 were due to poisoning and 1,319 were due to traumatic or medical causes (non-poisoning) (Table 1).

Table 1 Number of NDRDI deaths, by year of death, NDRDI 2004 to 2009 (N=3,334)

	2004	2005	2006	2007	2008	2009
All deaths	422	481	540	612	641	638
Poisoning (n=2015)	267	300	325	385	381	357
Non-poisoning (n=1319)	155	181	215	227	260	281

Poisoning deaths in 2009

The annual number of deaths by poisoning increased from 267 in 2004 to 381 in 2008, and dropped to 357 in 2009 (Table 1). The majority of deaths in each year were of males, who accounted for 68% of the poisoning deaths in 2009. The majority of those who died in 2009 were aged between 20 and 44 years; the median age was 37 years.

Just over half (51%) of all poisoning deaths involved more than one substance (polysubstance cases). The number of deaths where heroin was implicated rose to 108 in 2009, compared to 90 in 2008. Cocaine was implicated in 14% of deaths in the six-year period. The number of deaths where cocaine was implicated dropped to 52 in 2009, compared to 61 in 2008. In 2009, the number of deaths where methadone was implicated dropped to 66, compared to 80 in 2008.

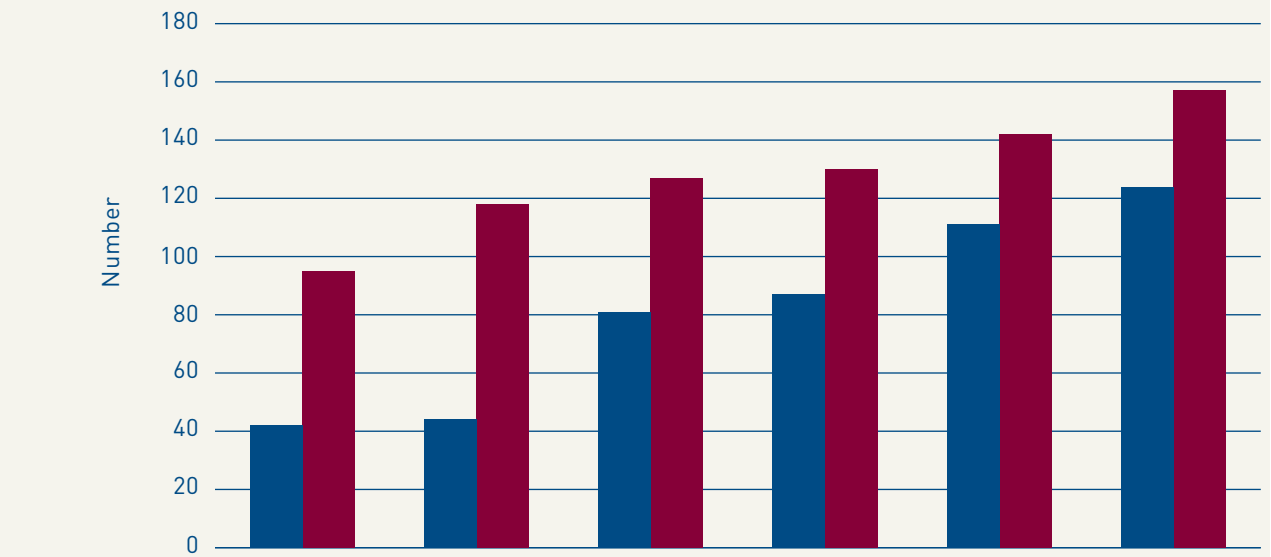
Update on drug-related deaths *(continued)*

Alcohol was involved in 40% of all poisoning deaths in the six-year period – more than any other substance. Prescription and over-the-counter medication was implicated in many cases. Benzodiazepines continued to play a major role in polysubstance poisonings.

In 2009 the highest number of poisoning deaths was recorded in the North Dublin City and County Regional Drugs Task Force area. The most significant increase between 2008 and 2009, at 95%, was in the Mid West Regional Drugs Task Force area.

Non-poisoning deaths in 2009

The number of non-poisoning deaths increased by 81% over the reporting period, from 155 in 2004 to 281 in 2009. Of the 281 deaths in 2009, over half (56%, 157) were due to trauma and the remainder (44%, 124) were due to medical causes.



	2004	2005	2006	2007	2008	2009
Medical	42	44	81	87	111	124
Trauma	95	118	127	130	142	157

Figure 1 Non-poisoning deaths among drug users, NDRDI 2004–2009 (N=1,258)

Deaths due to trauma

The number of deaths due to trauma increased annually, rising from 95 in 2004 to 157 in 2009 (Figure 1). The majority (82, 55%) of those who died in 2009 were aged under 35 years. The median age was 33 years. As in previous years, the majority (123, 78%) were male. The most common causes of death due to trauma in 2009 were hanging and choking.

Deaths due to medical causes

The annual number of deaths due to medical causes rose steadily over the reporting period, increasing from 42 in 2004 to 124 in 2009 (Figure 1). The majority (57%) of those who died were aged between 30 and 49 years. The median age was 41 years. Males accounted for 71% (88) of those who died. The most common medical causes of death in 2009 were cardiac events (42, 34%), respiratory infections (15, 12%) and cancer (13, 10%).

(Ena Lynn, Suzi Lyons and Simone Walsh)

1. Health Research Board (2011) *Drug-related deaths and deaths among drug users in Ireland: 2009 figures from the National Drug-Related Deaths Index*. Available at www.drugsandalcohol.ie/16365

The national community detoxification initiative

The Community Detoxification Protocol was originally developed in response to a number of identified needs, including queries from some service users who found it difficult to access outpatient detoxification, and from medical professionals who noted some challenges in providing an outpatient detoxification in the absence of structured community support.[1]

To address these issues, the Progression Routes Initiative brought together an interagency group in 2007 to develop a protocol, with members from the medical and community/voluntary sector as well as service user representatives. The protocol outlined the minimum standards for delivery of interagency support for outpatient detoxification. This included medical support provided by prescribing doctors and psycho-social supports provided by key workers. A key person was nominated as the local 'broker' to raise awareness of the protocol and support engagement of local professionals in community detoxification. The protocol was successfully implemented as a pilot in Dublin's North Inner City in 2008 and 2009.[2,3]

In November 2010, the Community Detoxification Steering Group reconvened and was expanded. The group includes representation from service user groups, research bodies, and medical, community and voluntary service providers.[4] The group reviewed and strengthened many aspects of the protocols, incorporating lessons learnt from the pilot in the North Inner City.

Community detoxification *(continued)*

One of the main changes was the division of the protocol into two separate sets of guidelines, one for methadone detoxification and one for benzodiazepine detoxification.[5,6] The protocols outline a structured, step-by-step detoxification process for both benzodiazepines and methadone and clarify the roles of each stakeholder (service user, doctor and key worker) in the process. This includes guidelines on psycho-social supports and information to support prescribers to work under these protocols.

While the minimum supports remain largely unchanged (weekly relapse prevention, care planning and regular medical appointments), certain areas of the protocols were bolstered to support the professionals who would work in line with them. Some of the changes include:

- Separation of protocols: differences in risks, processes and structural contexts for benzodiazepine prescription and detoxification and for methadone prescription and detoxification are now reflected in two separate sets of protocol documents, one for each substance.
- The detoxification process has been divided into four simple, logical steps with clear roles and responsibilities for each stakeholder in the process:
  - Brokering, preparation, detoxification, aftercare.
- Roles of the service user, key worker, doctor and broker clarified:
  - Provision of a comprehensive guide to the role of the local broker in the initiative.
- Inclusion of additional guidelines, information and resources for prescribing doctors.
- Comprehensive FAQ section which includes information on common queries, blocks and challenges encountered during community detoxification.
- Comprehensive, service-user friendly information on risks involved in detoxification are incorporated in to an agreement form which is included in the protocols.

Structured, supported out-patient detoxification should be one of a range of safe and accessible treatment options open to those seeking support with substance dependence. The evaluation of the North Inner City Community Detoxification Pilot revealed a successful initiative with promising retention rates and stakeholder satisfaction.[3] Due to interest from a number of areas in implementing the protocols and increasing numbers of referrals from outside the North Inner City, the new protocols and implementation structure will be adopted in a number of areas around Ireland as part of the National Community Detoxification Pilot 2012. The pilot was officially launched at the National Drugs Conference of Ireland 2011 and has so far received great support from the community/voluntary and medical sectors. The sites for the national pilot are: Cork/Kerry, the South East Regional Drugs Task Force (RDTF), the North Eastern RDTF, the Midlands, Bray, Ballymun, Ballyfermot, North Inner City Dublin and South Inner City Dublin.

Individuals from a variety of professions were nominated by each local or regional drugs task force to be trained in the role of broker for their area. Progression Routes delivered training in October 2011 and will provide an ongoing programme of support for independent brokers in the pilot areas. Over the coming two years, an evaluation will be conducted with the support of the evaluation sub-group, which includes expert input from the steering group.

It is hoped that ultimately the Community Detoxification Protocols will ensure that health services and community drug services across the country have the tools to collaborate to provide an accessible, timely, practical and consistent approach to detoxification for service users seeking to reduce benzodiazepine or methadone use. They present a cost-effective way of maximising existing resources in the community/voluntary and statutory sectors to ensure a realistic detoxification option is available for people when they are ready to change. By using the protocols, all stakeholders can work together to achieve a positive impact on the experiences of service users seeking out-patient detoxification.

For further information please contact Ms Aoife Dermody in Progression Routes at aoife.dermody@aldp.ie or at 01 878 6899.

(Aoife Dermody and Suzi Lyons)

1. Lyons S (2008) Community detoxification pilot scheme. *Drugnet Ireland*, (26): 18.
2. Health Research Board (2010) *2010 National Report (2009 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Dublin: Health Research Board. www.drugsandalcohol.ie/14714
3. A copy of the protocol and pilot evaluation is available at: www.progressionroutes.ie/uploads/docs/Evaluation.pdf
4. The Steering Group consists of: Chair, Mr Tony Duffin (voluntary organisations representative, Ana Liffey); Dr Brion Sweeney (National Drug Treatment Centre Board); Dr Austin O'Carroll (Safetynet); Dr Íde Delargy (ICGP); Dr Suzi Lyons (HRB); Dr Joanne Fenton (Access Team); Ms Irene Crawley (voluntary organisations representative, HOPE); Mr Brian Friel (Peter McVerry Trust); Mr Ruaidhri McAuliffe (UISCE Service Users Union); Ms Aoife Dermody (Progression Routes Initiative) Ms Caroline Gardner (Progression Routes Initiative); Dr Des Crowley (HSE); Advisor, Mr Joe Doyle (HSE).
5. Progression Routes (2011) *Community Detoxification Protocols: methadone*. Dublin: Progression Routes. Available at www.progressionroutes.ie
6. Progression Routes (2011) *Community Detoxification Protocols: benzodiazepines*. Progression Routes: Dublin. Available at www.progressionroutes.ie

Quantitative evidence of a heroin drought

The Drug Treatment Centre Board (DTCB) laboratory provides a nationwide service to the HSE Addiction Services, hospitals, general practitioners, voluntary organisations, the Department of Education (juvenile detention centres), the Probation Service, the Courts Service, the Medical Council, an Bord Altranais and occupational health departments. The Laboratory is accredited by the Irish National Accreditation Board (INAB) to ISO/IEC 17025 standard (INAB scope 169T).

The percentage of samples testing positive for drugs gives a quantitative measure of the extent of their use. With its large sample throughput, the DTCB laboratory is ideally placed to monitor trends in the prevalence of drugs in the drug-using population.

6-acetylmorphine (6-AM) is used as a marker for heroin use, being a unique metabolite only present when heroin has been taken. From 2005 to 2009, samples testing positive for 6-AM increased significantly, reaching an average of 29% in 2009. Samples testing positive for opiates followed a similar pattern. The data demonstrated a significant increase in the use of heroin in Ireland over this period.

A HRB paper on trends in treated opiate use[1] noted a 20% increase in the number of opiate cases presenting to drug treatment services between 2002 and 2007. In 2007 11,392 cases were treated for opiate use (mainly heroin) and three out of five people entering treatment cited an opiate as their main problem substance.

According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), heroin still accounts for the greatest share of morbidity and mortality related to drug use in Europe.[2] A decline in heroin use and associated problems was observed in the late 1990s, however from 2003-04 the trend became less clearly defined. Our data showed increased use of heroin between 2005 and 2009.

According to the UN Office on Drugs and Crime *World drug report 2011*, Ireland has the highest drug-related mortality rate in the EU and the third highest in the whole of Europe. The primary cause of poisoning deaths in Ireland was heroin and other opiates (such as methadone and codeine).

Polysubstances were found in 61% of all deaths by poisoning in 2008 as recorded by the National Drug-Related Deaths Index.[3] Heroin, methadone and other opiates (unspecified opiates and analgesics containing opiates) were implicated in 32.3%, 29.3% and 22.5% respectively of all cases. Benzodiazepines were found in 38.0% of all cases and played a major role in polysubstance deaths, being involved in more deaths by poisoning than any other substance in the period 1998–2008.

In November 2010 a heroin 'drought' was reported in the UK.[4] The report stated that hospitals were treating a growing number of drug users who had overdosed on heroin mixed with other substances. Concerns were expressed that what was being sold as heroin appeared to be adulterated with a powerful sedative and mixed with a high percentage of bulking agents like talcum powder or paracetamol.

This UK report was followed by anecdotal reports of a similar heroin drought in Ireland. A warning was issued to users on the website drugs.ie.[5] The Irish Needle Exchange Forum website also warned of the dangers of overdose, lowered tolerance and other health risks.[6] According to the INEF, the poor quality of the heroin available led some users to switch from smoking to injecting, and to use of 2.5ml needles to overcome the tendency of the contaminated heroin to congeal in 1ml needles, thus increasing overdose risk.

Study of the percentages positive of 6-acetylmorphine(6-AM) in samples tested over this period shows a very sudden decrease in positive samples in December 2010 (Figure 1), giving quantitative evidence of the extent of the drought in Ireland at this time, since heroin is the main drug of choice of the population being tested. This reduction in 6-AM positive samples is tracked closely by a similar decrease in opiate positive samples (as would be expected).

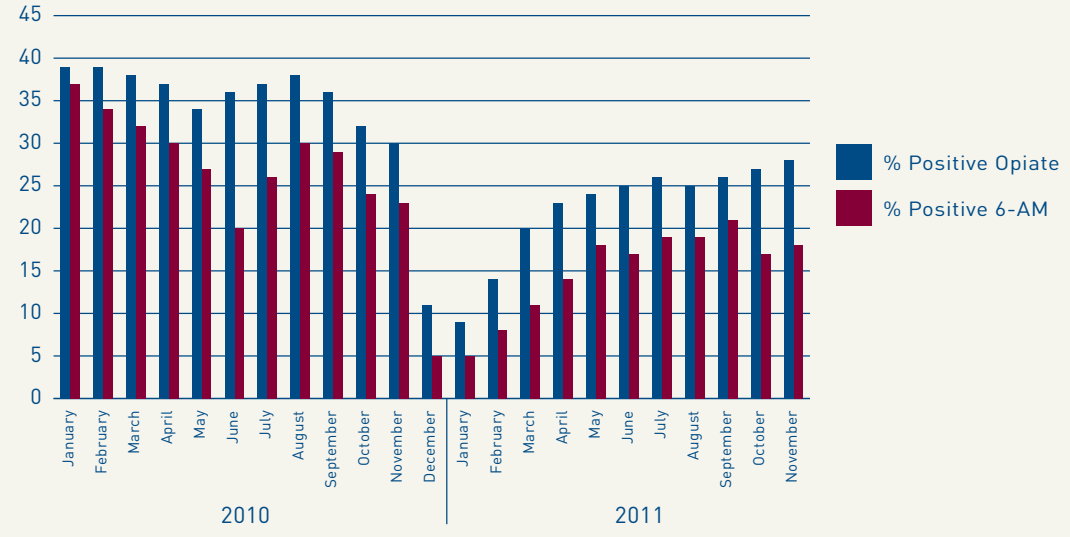


Figure 1 Opiate and 6-acetylmorphine (6-AM) positive samples 2010–2011

Evidence of heroin drought *(continued)*

Looking at the data in 2011, it is clear that, while there has been some recovery in supply of heroin since January, there is still a significant reduction in the 6-AM positive samples. Only 18% of the samples tested in November 2011 were 6-AM positive, as compared to 37% in January 2010. Opiate positives also decreased, from 39% to 28%.

Our data indicate that either the availability of heroin is significantly reduced currently or the heroin available in the market at this time is lower in strength than that normally available, thus giving rise to fewer positive samples.

In February 2011 three overdose deaths occurred in Kilkenny, followed by three deaths in Dublin. The overdoses were reportedly the result of batches of 'high quality' heroin coming into circulation following a heroin 'drought' over Christmas and the new year.[7] However, in March 2011 fears were raised that the heroin involved in the six deaths had been mixed with benzodiazepines.[8]

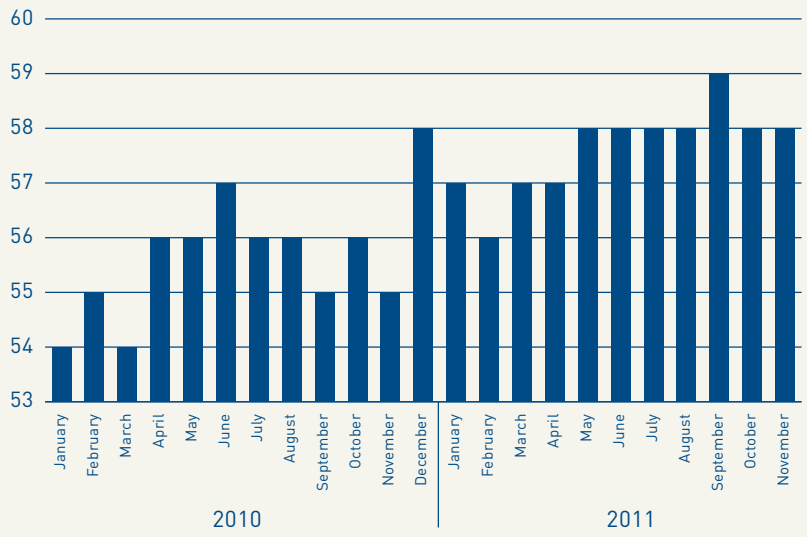


Figure 2 Benzodiazepine positive samples 2010–2011

A significant increase in benzodiazepine use has occurred since 2005. Benzodiazepine positive samples increased from 51% in 2005 to an average of 56% in 2010. Benzodiazepine positive samples spiked in December 2010, coinciding with the heroin drought (Figure 2). There is an ongoing increase in benzodiazepine positive samples (averaging 58% currently). This may reflect market response to an ongoing reduction in heroin availability or strength by increased use of benzodiazepines as a substitute.

The extent to which this increase could be due to heroin being 'cut' or substituted with benzodiazepines is unknown. These drugs are also sold to a significant extent in the illicit drug market. In 2010 the Irish Medicines Board seized 822,484 units of counterfeit medicinal products, of which 153,483 units were sedatives, including diazepam, zopiclone and flurazepam.[9]

Unfortunately, it is difficult to quantify the extent of the increase in use of benzodiazepines, as a large proportion of the drug-using population are prescribed benzodiazepines, and increased illicit use in this cohort will not necessarily be reflected in the figures.

There was also a temporary peak in cocaine use at the time of the heroin drought in December2010, when apparently it was being used as an alternative to heroin (Figure 3) but positive samples have now returned to the level seen prior to the heroin drought.

According to an article in *Druglink*,[10] unpublished figures from the UK Forensic Science Service showed that the average purity of street heroin there was at an all-time low of 13.1% in January 2011 (from an average purity of 30–40%). Increased use of black market diazepam was feared to have been responsible for a number of deaths in Cardiff. Possible causes of the heroin drought cited included fungal blight of the poppy crop, recent law enforcement operations disrupting the supply network, stockpiling by wholesalers to increase the price or diversion of supply to an easily accessed and growing Russian market. If the reason for the drought is one of the last, it could have a more long-term impact on the situation.

The first EMCDDA Trendspotter meeting in October 2011 on 'Recent shocks in the European heroin market: explanations and ramifications'[11] found that a small number of countries including Ireland experienced a severe shortage of heroin most heavily felt between November 2010 and March 2011. Divergent situations existed in Europe and the reasons for the drought were multifaceted. In areas where heroin drought was experienced drug users were reportedly increasing use of both alcohol and non-prescribed benzodiazepines to fill the vacuum.

The heroin drought seems to have had an ongoing impact on heroin supply in Ireland as heroin use continues to be down on previous figures. However, this has been counterbalanced by an increase in benzodiazepine use. The significant rise in benzodiazepine use is worrying considering their role in polysubstance deaths, although perhaps this may be mitigated by the corresponding decrease in heroin use which seems to have occurred. The effect of the heroin drought in terms of mortality among drug users will only evolve over time.

Evidence of heroin drought *(continued)*

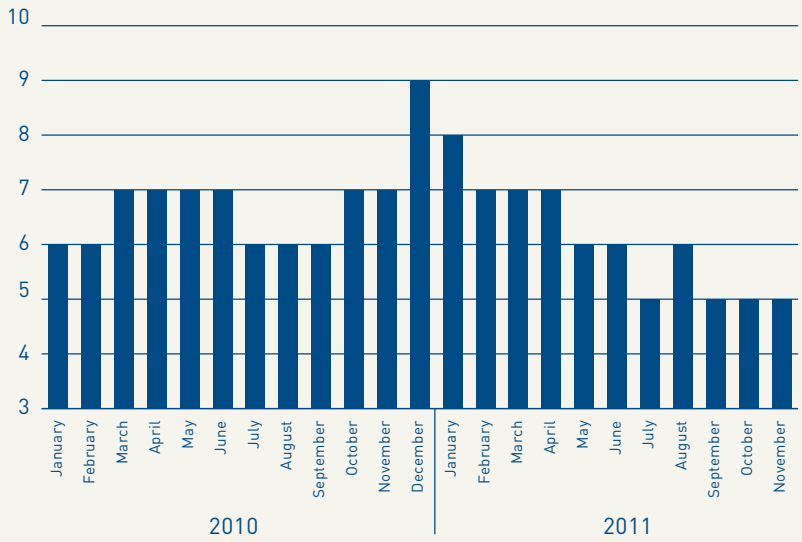


Figure 3 Cocaine positive samples 2010–2011

(Siobhán Stokes, Principal Biochemist, DTCB laboratory)

1. Carew AM, Bellerose D, Lyons S and Long J (2009) *Trends in treated problem opiate use in Ireland, 2002 to 2007*. HRB Trends Series 7. Dublin: Health Research Board.
2. European Monitoring Centre for Drugs and Drug Addiction (2011) *Annual report 2010: the state of the drugs problem in Europe*. Luxembourg: Publications Office of the European Union.
3. Health Research Board (2011) *Drug-related deaths and deaths among drug users in Ireland: 2008 figures from the National Drug-Related Deaths Index*. www.drugsandalcohol.ie/14618
4. Taylor D (2010, 1 November) Heroin shortage in UK is 'putting lives at risk'. *The Guardian*. www.guardian.co.uk/society/2010/nov/21
5. Drugs.ie (2010, 7 December) Services alert: heroin drought in Dublin and across Ireland. www.drugs.ie/news/
6. http://inef.ie/documents/Heroin%20_alert%20guidelines(1).pdf
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8. Falkiner K (2011, 20 March) Heroin drought is killing addicts. *The Sunday Mirror*. www.thefreelibrary.com
9. Irish Medicines Board (2011, 25 March) *Irish Medicines Board reports 66% rise in illegal medicines detained in 2010*. Press statement. www.imb.ie/EN/News
10. Simonson P and Daly M (2011) The great heroin crash. *Druglink*, 26(2): 8–9. http://issuu.com/drugscope/docs/druglink_march_april_2011
11. EMCDDA (2011) *Recent shocks in the European heroin market: explanations and ramifications*. Trendspotter summary report. www.emcdda.europa.eu/events/2011/trendspotter

New drink driving limits and penalties in Ireland

The drink drive limit in Ireland was recently reduced and is now in line with European levels. The new Blood Alcohol Concentration (BAC) limit is 50 milligrams (mg) for all drivers, and 20mg for specified drivers, defined as learner or newly qualified drivers (for a period of two years after passing their driving test) or professional drivers (of buses, goods vehicles and public service vehicles).

A new penalty system has been introduced to deal with offences that come under the new limits. Under the previous system, all drink driving offences were dealt with in the courts and those who were convicted were automatically disqualified from driving. Under the new system, a driver who fails a preliminary breath test at the roadside will still be arrested and required to provide an evidential breath, blood, or urine specimen at a Garda station. However, if the driver's BAC does not exceed 100mg and they are not already disqualified from holding a driving licence at the time of detection or have not availed of the administrative fixed penalty notice option in the preceding three years, he or she will be served with a fixed penalty notice (Table 1). A driver can only avail of the fixed penalty option once in a three-year period.

New drink driving limits *(continued)*

Table 1 Drink driving limits and penalties under the new system

BAC level	Specified drivers (learner, newly qualified, and professional drivers)	All other drivers
20–80mg*	€200 fine Disqualification from holding a driving licence for 3 months	
50–80mg*		€200 fine Three penalty points which will remain on a licence record for three years Any driver accumulating 12 points in a three-year period will be disqualified from driving for a period of 6 months.
80–100mg		€400 fine Disqualification from holding a driving licence for 6 months

*If a driver cannot produce their driving licence when required to undergo a preliminary breath test, the lower limit of 20mg will apply until such time as the driver produces their licence.

Court proceedings will not be initiated if the driver pays the fixed charge and accepts the penalty. If a driver does not accept the fixed penalty notice and goes to court and is unsuccessful in appealing, the penalties are increased; for first offences where the BAC does not exceed 80mg a six-month disqualification period applies, while a one-year disqualification period applies for offences where the BAC is 80–100mg.

Where the BAC detected is above 100mg, or above 80mg for a specified person, where the person is not eligible to be served with a fixed penalty notice, or where payment has not been made in respect of a fixed penalty notice, the court penalties relating to disqualification from driving outlined in Table 2 apply on conviction. In addition, the court may apply a fine up to of €5,000 and/or six months in prison.

Table 2 Disqualification periods that apply to drink driving offences convicted in court

BAC level	1st offence	2nd offence
<80mg (specified drivers only)	6 months	1 year
80–100mg	1 year	2 years
101–150mg	2 years	4 years
151mg+	3 years	6 years

Further information on the new drink driving limits may be obtained from the Road Safety Authority www.rsa.ie or from the Department of Transport, Tourism and Sport www.transport.ie.

(Deirdre Mongan)

AAI conference addresses alcohol-related harms

Alcohol Action Ireland held a conference titled 'Alcohol: Where's the harm?' on 15 November in the Royal College of Physicians. The conference was opened by **Róisín Shortall**, Minister of State with responsibility for Primary Care at the Department of Health, who said that parental attitudes to drinking were sometimes 'ambivalent' and 'irresponsible'. She also said that the 'time was right for action to be taken' and that she wanted to focus attention on minimum pricing and tougher enforcement of underage selling and distance selling of alcohol, such as phone and online ordering of alcohol.

Fiona Ryan, director of Alcohol Action Ireland, launched the results of a national survey commissioned by her organisation which looked at the harms and damage caused by other people's drinking. The sample consisted of 1,001 adults aged 16 and over and interviews were conducted by telephone as part of a Behaviour and Attitudes Telebarometer survey.

Almost six in 10 respondents stated that they had been affected by alcohol-related incidents in their community in the previous year as a result of someone else's drinking; this included 45% who stated that they had gone out of their way to avoid drunk people or places where drinkers were known to hang out, 21% said that they had been kept awake at night or disturbed, 12% had been verbally abused and 8% had been threatened. Harms were more frequently experienced by men, younger people and those living in urban areas. Nine per cent reported that either they or a family member had been assaulted by a person under the influence of alcohol, which corresponds to 318,000 of the total population aged 16 and over. However, only 45% of those who had personally been assaulted reported the assault to the police.

In relation to property damage, 7% stated that their house or car had been damaged, 13% had had to clean up outside their house, and 5% had had to pay to repair damage to home, car or property as a result of someone else's drinking. Ms Ryan said that, based on these results, the estimated cost to the country of damage, clean-up costs and repairs was €164.9 million.

Ann Hope outlined the Irish and international evidence in relation to the link between alcohol and crime and identified the factors most associated with alcohol-related violence as regular risky drinking, being male and being young. From a policy perspective, she said that we needed licensing laws with clear public health objectives, a review of outlet density and a ban on cheap promotions. **Sean Byrne** presented an analysis of the economic costs of alcohol-related crime in Ireland in 2010, which amounted to €1.8 billion. This figure

AAI conference *(continued)*

includes the costs of policing alcohol-related crime, the costs to the court, prison and probation systems and the costs in anticipation of crime.

Superintendent **Colette Quinn**, director of the Garda Juvenile Diversion Programme, described how the programme is dealing with the issue of alcohol, while **Sandra Coughlan** described the evolution of the Club Cork project and the development of additional regional projects in the HSE South Region. **Martine McKillop** and **Stevie Lavery** discussed how Northern Ireland is tackling alcohol-related crime.

Clíona Saidléar of Rape Crisis Network Ireland highlighted the link between alcohol and sexual violence and said that alcohol consumption, especially drinking to intoxication, was a feature in a high proportion of rapes committed in Ireland. She also discussed the role of alcohol in Irish culture. She said that in Irish law and legal practice alcohol is not a mitigating factor in sexual offence cases, however, in Irish culture alcohol is often cited as a mitigating factor for so-called 'uncharacteristic' behaviour, such as violence or rape committed while intoxicated. **Sharon O'Halloran**, director of Safe Ireland, spoke of the link between domestic violence and alcohol, as did **Christine Toft** of Alcohol Concern in the UK. There is a huge overlap between alcohol and domestic violence; perpetrators often use alcohol before or during the incident, while victims may use alcohol to numb the pain of the abuse. **Thomas Bibby** of MOVE (men overcoming violence) Ireland stressed the need for greater multi-agency collaboration as sexual/domestic violence and drug/alcohol use are overlapping issues. He concluded that by working together we can improve the way services are delivered, providing better protection to women and children.

Copies of all the presentations may be accessed on Alcohol Action Ireland's website http://alcoholireland.ie/.

(Deirdre Mongan)

Alcohol consumption and pregnancy: a retrospective cohort study

This study estimated the prevalence of peri-conceptional alcohol consumption and the relationship between it and maternal characteristics and perinatal outcomes.[1] This was a retrospective cohort study of 61,241 singleton births at a large Dublin maternity hospital in the period 2000–2007, based on antenatal, delivery, postnatal and neonatal records. Self-reported alcohol consumption at the booking visit (usually between 12 and 20 weeks gestation) was categorised as: never (lifetime abstainers), low (0–5 units per week), moderate (6–20 units per week) and high (more than 20 units per week).

The numbers and proportions reporting each category of alcohol consumption were: abstainers (11,613, 19%), low or occasional drinkers (43,455, 70.9%), moderate drinkers (6,059, 9.9%), and high or heavy drinkers (114, 0.2%). The categories reporting any level of alcohol consumption accounted for 81% of the cohort.

The profile of those who never drank alcohol indicates that 23% were under 25 years old, 73% were married, 32% were housewives, 25% were unemployed, 57% were not Irish, 10% had private health care, 68% had had at least one previous pregnancy, 36% had not planned their current pregnancy, 23% had booked antenatal care after 20 weeks gestation, 18% smoked cigarettes, 1.5% had used illicit drugs at some point in their life and 21% had been referred for antenatal care by a social worker.

The profile of low alcohol consumers indicates that 18% were under 25 years of age, 66% were married and 86% were Irish. Just over one third (34%) were in non-manual employment, while one quarter were professionals, managers or business owners. Twenty-eight per cent had private health care. Just under three-fifths (59%) had had at least one previous pregnancy and 34% had not planned their current pregnancy. Only a small minority (11%) had booked antenatal care after 20 weeks gestation. Twenty-three per cent smoked during their current pregnancy and less than 1% had used illicit drugs at some point in their life. Twelve per cent had been referred for antenatal care by a social worker.

The profiles of low and moderate alcohol consumers were similar in that these groups were marginally older than those who had never consumed alcohol. The occasional drinkers were less likely to smoke than the moderate drinkers, and more likely to have had a previous pregnancy and to have planned this pregnancy. The moderate drinkers were more likely than the occasional drinkers to be single, to smoke cigarettes and to have private health insurance.

The profile of heavy drinkers was very different to that of the other three groups: they were very young (45% of the group were under 25 years of age), just under 80% were single, one third were unemployed, 90% were Irish, only 3.5% had private health care, 68% were pregnant for the first time, 75% had not planned their current pregnancy, 70% smoked during their pregnancy, 9% had used illicit drugs at some point in their life and 40% had been referred by a social worker.

The profiles of those who consumed alcohol were compared to the profile of the group who never drank alcohol. Factors associated with moderate alcohol consumption included being in employment, being of Irish nationality, having private health care and smoking. Factors associated with high consumption included maternal age less than 25 years and illicit drug use. High alcohol consumption was also associated with very preterm birth (less than 32 weeks gestation) even after controlling for socio-demographic factors.

Only three cases of Fetal Alcohol Syndrome (FAS) were recorded (0.05 per 1,000 total births), one each in the low, moderate and high consumption groups. The fact that cases of FAS occurred in the low and moderate consumption groups may be explained by under-reporting of alcohol consumption by pregnant women, as FAS does not normally occur in the infants of low and moderate users.

There is a need to ensure a consistent and accurate approach to recording alcohol intake at the first antenatal visit. Other countries include measures of binge drinking at this visit and, given that binge drinking is very common in Ireland, this may be an important measure to identify risk of and prevent negative outcomes. It is clear that some pregnant women currently under-report their alcohol consumption.

This and other studies completed from routinely collected patient data at this large Dublin maternity hospital demonstrate the value of analysing such data to identify issues and improve current practice.

(Jean Long)

1. Mullally A, Cleary BJ, Barry J, Fahey T and Murphy DJ (2011) Prevalence, predictors and perinatal outcomes of peri-conceptional alcohol exposure: retrospective cohort study in an urban obstetric population in Ireland. *BMC Pregnancy and Childbirth*, 11: 27 (11 April 2011).

Children's exposure to risks from parental drinking

A recent report, *Hidden realities – children's exposure to risks from parental drinking in Ireland*,[1] examined the impact of hazardous and harmful use of alcohol on children, in particular in the north west of Ireland. This was done by analysing general population surveys and agency records, and interviewing family support services.

Main findings

General population survey

The National Drinking Surveys of 2006 and 2010 were combined for this analysis, which gave a total sample of 2,011 adults aged 18 years and over. Over half of all adult drinkers who had children living in their household engaged in regular hazardous drinking (defined as consuming the equivalent of four pints of beer or one bottle of wine or seven spirits in one sitting at least once a month). When these figures are applied to the national population, approximately 271,000 children aged under 15 years are exposed to risk from hazardous drinking by parents. One in seven (14%) adults reported that they had experienced family problems as a result of someone else's drinking, which equates to approximately 449,000 families negatively affected by alcohol. Family problems were reported more often by women, those under 35 years and those in the lower social class.

The 2010 survey also contained questions that measured children's exposure to neglect or abuse because of someone else's drinking. These questions were asked of respondents who had parental or guardianship responsibility. One in ten adults reported that children for whom they had parental responsibility had, as a result of someone else's drinking, experienced one or more of the following harms: verbal abuse, physical abuse, witnessing violence in the home, or being left in unsafe situations. Harms were reported more often by parents who engaged in regular hazardous drinking and by those in the lower social class.

National Drug Treatment Reporting System

For the period 2007–2009, 3,234 cases living in the north west entered treatment for problem substance use, of whom 2,417 reported that alcohol was their only problem substance. Of these 2,417 cases, 29% were living in households with children.

Donegal community alcohol survey

A community alcohol survey was completed by 554 participants across six communities in Co Donegal. The level of awareness of risk to children as a result of someone else's drinking varied from 12% to 57%. In five of the six communities, awareness of children being verbally abused as a result of someone else's drinking was the highest ranked risk; this was followed by awareness of children being left in an unsupervised or unsafe situation.

National child protection data results

National data reported by the HSE for 2006–2008 showed an increase in the number of reports received by social work departments in relation to child protection issues, from 21,040 reports in 2006 to 24,688 in 2008. The National Child Care minimum dataset for 2008 recorded the principal reason reported for child welfare concerns. For 15% the principal reason was a family member abusing drugs/alcohol, and for 3% the principal reason was the child abusing drugs. In Co Donegal 24% of child welfare concerns were due to a family member abusing drugs/alcohol, while the corresponding figure for Sligo/Leitrim/West Cavan was 16%.

RAISE data

RAISE is a case management IT system used by social workers. Analysis of these data revealed that alcohol abuse was mentioned in over a third (36%) of child protection cases in Co Donegal.

Focus groups with frontline staff working in family services

Focus groups were conducted in Donegal and Sligo and included social workers, youth workers, addiction counsellors and community support services (NGOs). For most of the frontline staff an intervention with families regarding alcohol problems only occurred when the problems had reached a crisis point. Some of the burdens borne by children as a result of parental alcohol abuse included role reversal, whereby children took responsibility for household tasks and caring for their parents, and keeping the alcohol problem secret. These burdens can have considerable negative effects on a child's schooling and social life.

Conclusion

The results of this study indicate that children in Ireland and the North West are exposed to considerable risks as a result of someone else's drinking and there is a need to reduce the level of hazardous drinking among adults in Ireland. The author concludes that 'effective family support services are needed that actively address family alcohol problems through prevention and early intervention, as well as the more specialised treatment services as part of an integrated strategy to tackle family alcohol problems, which impact on the welfare of children'.

(Deirdre Mongan)

1. Hope A (2011) *Hidden realities: children's exposure to risks from parental drinking in Ireland*. Letterkenny: North West Alcohol Forum Ltd. www.drugsandalcohol.ie/16250

A family affair? Seminar on parental substance misuse

Minister of State Róisín Shortall gave the opening address at the seminar 'Parental substance misuse: addressing its impact on children' on 18 October.[1] The event was jointly hosted by the National Advisory Committee on Drugs (NACD), the Social Inclusion Unit of the Health Service Executive and Alcohol Action Ireland.

Minister Shortall congratulated the authors of the report, commenting on its timely focus on young people who were at risk because of their parents' substance misuse. 'The real challenge is to break this cycle. The fact that substance misuse in one generation can have impacts that cascade into the lives of those following illustrates the level of importance that we must place on targeted measures aimed at breaking the cycle and safeguarding the next generation.' As well as acknowledging the substance misuser's need to focus on recovery and a life without drugs, the Minister also spoke about recognising children in their own right and consulting them on issues that affect their lives. She also spoke about problem alcohol use as an important public health issue, the need to reduce the amount of alcohol consumed in the country, and the development of a National Substance Misuse Strategy.

Dr Justine Horgan, senior researcher at the NACD and author of the report *Parental substance misuse: addressing its impact on children*,[2] presented some of the key messages from her review of the literature (see page 28 for a summary of that report).

This was followed by some lively round table discussions where the seminar participants were asked to identify important themes around 'what works in providing support, and the challenges in providing support, to children living with parental substance misuse'. A summary of the discussions will be provided by the NACD but a flavour of the responses is given here. Some of the themes identified for what works were early intervention, interagency work, listening to children and specific training in addiction. Some of the themes around challenges were: getting the child's voice heard, issues of fathers, funding and poor perception of services by the families.

Norah Gibbons (chair of Alcohol Action Ireland and director of advocacy at Barnardos) spoke about prioritising children in policy and practice.[3] She spoke eloquently about the very real impact of parental substance misuse on children. In some cases the child has to become 'the parent', looking after younger siblings, worrying about the adult parent, children who were often 'leading lives of quiet desperation'. Finally, she supported the need for a constitutional amendment to ensure children's rights in this country.[4]

There were four parallel workshops in the afternoon: Learning for service responses – Ballyfermot Star;[5] North West Alcohol Forum – The Families Matter Programme;[6] Building knowledge and skills for better outcomes for children – the role of *Children First*;[7] and Hidden Harm Action Plan, a partnership approach for better outcomes for children living with parental drug and alcohol misuse.[8]

Paul Barron, assistant secretary at the Department of Health, chaired the final session. Another of the other key speakers was Mary Forrest, clinical director of CrossCare Teen Counselling, who spoke particularly about teenagers. She outlined some of the changes she had seen in her work, remarking that although teenagers now were more willing to seek counselling, funding for services was being reduced. She said that there was now greater awareness of the negative impact of parental substance misuse on children, which was a positive sign, and she welcomed the development of the new combined substance misuse strategy.

Pictured at the NACD conference (l to r): Fiona Ryan, Director of Alcohol Action Ireland; Dr Des Corrigan, NACD; Minister of State Róisín Shortall; and Dr Justine Horgan, NACD (Photo: Conor Healy)

Phil Garland, assistant national director of HSE Children and Family Services, also spoke in the afternoon. He welcomed the seminar as an opportunity for policy makers and front line staff to consider the issues around this problem. He stated that there needed to be collaboration on all levels, between agencies, to support children whose parents have a substance misuse problem 'and to increase the effectiveness of frontline child protection and addiction services with collaborative interventions based on measurable change outcomes'.

Frances Fitzgerald TD, Minster for Children and Youth Affairs, gave the closing address at the seminar. She spoke about the importance of interagency work for all those involved with children at national, regional and local level and how the new Department of Children will play a key role in supporting this process.

(Suzi Lyons)

1. See the NACD report on the conference at http://www.nacd.ie/publications/index.html
2. Horgan J (2011) *Parental substance misuse: addressing its impact on children. A review of the literature.* Dublin: NACD. Available on-line only, at http://www.nacd.ie/publications/index.html
3. A transcript of Ms Gibbons's presentation is available at www.nacd.ie/publications/prioritising_children.pdf
4. For further information see www.barnardos.ie/what-we-do/campaign-and-lobby/childrens-rights.html
5. www.nacd.ie/publications/a_family_affair.html
6. www.nacd.ie/publications/strengthening_families_programme.html
7. www.nacd.ie/publications/knowledge_and_skills.html
8. www.nacd.ie/publications/hidden_harm.html

Prioritising children in drug policy and practice

The needs of children of drug-using parents are attracting attention from policy makers and service providers both here in Ireland and in Europe.

Barnardos and the Family Support Agency

On 10 October 2011 Barnardos and the FSA launched *Parenting positively – coping with a parent's problem drug or alcohol use*, a new resource for children, teenagers and their parents to support them in understanding and dealing with difficulties that can result from a parent's problem drug or alcohol use: it not only gives parents an insight as to how their behaviour, or that of their partners, is affecting the child, but also helps the child to understand what is happening and what they can do to help themselves.

The resource comprises three booklets – one for children aged 6–12, one for parents of children aged 6–12, and one for parents of teenagers. The booklets are written in a question and answer format, with contributions from children and parents who have experienced the impact of alcohol and drugs on their family. Teenagers are catered for with an online resource available at www.barnardos.ie/teenhelp. The Parenting Positively series of booklets, of which this resource is the latest, are available free to download from www.barnardos.ie or www.fsa.ie .

National Advisory Committee on Drugs, Health Service Executive and Alcohol Action Ireland

On 18 October 2011 the NACD, HSE and Alcohol Action Ireland hosted a one-day seminar, attended by policy makers and service providers, at which a report, *Parental substance misuse: addressing its impact on children*, was launched. Having reviewed all the major international research on the impact of parental substance misuse on children, author Dr Justine Horgan, senior researcher with the NACD, reports that children of substance misusers are more likely to experience problems with mental health, social skills, academic achievement and substance use. The report is available for download at www.nacd.ie .

Horgan identifies five priority areas for policy makers, service providers and researchers to consider:

1. Consequences of parental substance misuse for child development: substance misuse during pregnancy can have harmful effects on the baby.
2. Consequences for parenting and family life: the stress owing to parental substance misuse combined with the increased likelihood of the child being in care and/or suffering homelessness, results in these children being at a high risk of emotional isolation and/or social marginalisation.
3. Impact on child outcomes: for many affected children, the effect continues into their adult lives; for some, the impact can be multifaceted and persist not only into adult life but even into the lives of the next generation.
4. Response to parental substance misuse: more integrated working between addiction services, children's services and medical professionals is needed to help reduce the negative impact of parental drug and alcohol misuse on children and the wider family.
5. Future research and data needs: five research areas are identified that would help to fill gaps in Ireland's research, statistics and information regarding children of parents who misuse drugs.

Key recommendations include:

- Additional research and data collection to properly estimate the number of children whose parents have substance misuse problems.
- The HSE Children First guidelines to be used by all services and organisations working regularly with children who experience parental substance misuse and with their parents.
- Assess the extent to which adult alcohol and drug treatment services are supporting parenting and liaise with child support and other relevant services.
- Assess the extent to which professional education and training in areas such as youth work, psychology, addiction support, guidance, counselling and childcare can address children affected by parental substance misuse.
- Educate women on the adverse effects of consuming alcohol and drugs during pregnancy and train medical professionals so that they can raise awareness among their patients of the risks of consuming these substances.
- Consider appropriate interventions and ways of working for primary health care staff who are involved in the early stages of children's lives such as public health nurses, GPs and community mothers.

Speaking at the seminar, Norah Gibbons, chair of Alcohol Action Ireland and director of advocacy at Barnardos, called for the following:

1. Invest in prevention and early intervention services by increasing collaboration between organisations and functions, and increasing awareness and understanding among service providers of the needs of children and families damaged by parental alcohol problems. Develop joint local protocols between addiction services, health and social services, adult and children's services, in both the voluntary and statutory sectors.
2. Make services more holistic, i.e. a 'whole family' approach, such as that provided by Northern Ireland's 'Hidden Harm Action Plan' for children living with parental substance misuse.
3. Provide services and supports directly to children, for example through self-referral services, helplines, in-school counselling, therapeutic support or emergency accommodation.
4. Ensure organisations are clear about their responsibilities under Children First by putting the guidelines on a legislative basis. Drug and alcohol services have a crucial role to play here, in terms of identifying parents who are need of support with their parenting and caring responsibilities and providing appropriate treatment, guidance and referral.
5. Amend the Constitution to enshrine children's rights.

Prioritising children in drug policy and practice *(continued)*

What will you do differently/how will you act to prioritise children in your organisation?

What does your organisation do to ensure that children are seen and heard?

What will your organisation do differently?

Norah Gibbons

European Monitoring Centre for Drugs and Drug Addiction

Earlier this year the EMCDDA invited the national focal points in each of the 27 member states of the EU to report on drug-using parents and their children within their country – the current situation and the risks and harms, the legislative and policy framework, and the nature of responses. A summary report is expected to be published during 2012.

(Brigid Pike)

Impact of legislation to control head shops

The **Criminal Justice (Psychoactive Substances) Act 2010** was implemented in response to the emergence of 'head shops' selling 'legal highs'. After the Act came into force, the vast majority of such shops were closed down.

A number of academic articles have questioned the rationale behind the recent legislative approaches to controlling the legal high phenomenon. Reuter, in a review of international responses to new psychoactive substances, is extremely critical of the approach taken in Ireland.[1] In criticising the regulatory impact analysis conducted by the Department of Justice and Equality,[2] which included a cost-benefit analysis of the proposed legislation, Reuter states that the approach adopted was 'of limited conceptual sophistication' and ultimately naïve:

> Consider for example Ireland, which has been active in the field. It has published an analysis of regulatory options for head shops, which are prominent there. The assessment makes no mention of any potential adverse effects of prohibition. It identifies the dangers of not regulating and the potential gross gains of the regulatory options. The only negative aspects of regulation that are given any attention are the costs of operating the regulation. It is naïve compared to, for example, environmental regulatory analysis, which requires much more careful balancing of costs and benefits of each option. (p. 7)

In a similar vein, Ryall and Butler set the controversy over head shops in Ireland and the resulting legislation within the framework provided by the sociological concept of 'moral panic'.[3] They describe this as a formulation of social policy whereby, in this instance, 'the negative societal consequences of psychoactive drug use tend to be exaggerated – by the media and a range of other "moral entrepreneurs" – thereby serving to legitimate extreme policy responses which, paradoxically, may amplify the very deviance they were intended to curtail' (p. 304). 'Based on semi-structured interviews with some of the main stakeholders in this process and set against a background of saturation media coverage of this phenomenon, this article presents and assesses competing perspectives on the head shop issue' (p. 303).

The authors suggest that, 'from a conventional drug-control perspective, recent legislative measures in Ireland may be seen as representing effective cross-cutting activity between the health and criminal justice sectors. From a harm reduction perspective, however, this policy response may be seen as an example of moral panic in that media portrayals greatly exaggerated the ill effects of head shop products, in the process stoking public anger rather than encouraging rational debate' (p. 303). Although the authors acknowledge 'a degree of sophistication on the part of all those interviewed' (p. 310), including head shop owners, users, law enforcement personnel, policy advisors and the minister responsible for the drug strategy at the time, ultimately they conclude that 'the great Irish head shop controversy ended in a clear victory for traditional "war on drugs" values' (p. 310).

The National Advisory Committee on Drugs published a study on new psychoactive substances and the outlets supplying them.[4] The review, conducted between May and August 2010, sought to assess the availability and accessibility of new psychoactive substances in retail outlets throughout Ireland and online. With regard to the impact of new legislative measures, one of the conclusions reached by the authors was that 'habitual drug users who were attracted by the legality and easy availability of head shop products are likely to return to "traditional" illegal substances' (p. 79). This view may be borne out by results of the fourth all-Ireland general population drug prevalence survey showing a fall in ecstasy use in the last year, which may be partly explained by the proportion of young people reporting the use of new psychoactive substances sold in head shops and online (see article pages 6–7).

(Johnny Connolly)

1. Reuter P (2011) *Options for regulating new psychoactive drugs: a review of recent experiences*. London: UK Drug Policy Commission.
2. Department of Justice and Equality (2010) *Criminal Justice (Psychoactive Substances) Bill 2010: regulatory impact analysis*. Dublin: Department of Justice and Equality.
3. Ryall G and Butler S (2011) The great Irish head shop controversy. *Drugs: education, prevention and policy*, 18(4): 303–311.
4. Kelleher C, Christie R et al. (2011) *An overview of new psychoactive substances and the outlets supplying them*. Dublin: National Advisory Committee on Drugs. (See also Long J and Connolly J (2011) Report on new psychoactive substances and the outlets supplying them. *Drugnet Ireland*, (39): 9.)

Drug tests in Irish prisons

Information on drug testing in prisons in 2010 was obtained from the Irish Prison Service. These data indicate that more than 22,500 voluntary tests were carried out in 2010 to monitor drug use and responses to treatment. The tests included those carried out on people who were classified as inmates, and excluded committals. It may be assumed therefore that the positive test results relate to drugs or alcohol consumed inside the prison.

The results indicate that a large proportion of drug users in treatment are opiate dependent and are in receipt of prescribed methadone. The numbers of positive tests for benzodiazepines indicates that benzodiazepines are prescribed for a significant minority of prisoners attending drug treatment, or that these prisoners are obtaining benzodiazepines through unregulated sources. The common illicit drug metabolites detected indicate use of cannabis and opiates in prison (Table 1). Cocaine, amphetamines and alcohol were detected in a very small number of tests, indicating that these drugs are rarely used in the prison environment.

The profile of positive cannabis, opiate and benzodiazepine tests indicates use of these drugs among prisoners tested in Mountjoy Main prison. A sizeable number of inmates tested positive for benzodiazepines in the Dóchas Centre and Limerick prison. There is a sizeable amount of cannabis use at Loughan House and Mountjoy Main. There is a small but notable amount of benzodiazepine use at Castlerea prison, Cloverhill prison, Cork prison, Portlaoise prison, Loughan House, and the Midlands prison. There are small but notable amounts of opiate use at Portlaoise and the Midlands Prisons.

(Jean Long)

Table 1 Number of drug tests, and number (%) of positive tests, by prison and by drug type, 2010

Prison	No. of tests*	Alcohol		Amphet-amines		Benzo-diazepines		Cocaine		Methadone		Opiates		Cannabis	
		n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)	n	(%)
Mountjoy Main	**5266**	20	(0.4)	2	(0.0)	2301	(43.7)	24	(0.5)	3864	(73.4)	2308	(43.8)	2011	(38.2)
Mountjoy Medical Unit	**2871**	9	(0.3)	0	(0.0)	245	(8.5)	2	(0.1)	1372	(47.8)	318	(11.1)	273	(9.5)
Dóchas Centre (Female)	**1768**	9	(0.5)	2	(0.1)	959	(54.2)	25	(1.4)	1610	(91.1)	296	(16.7)	271	(15.3)
Training Unit	**2270**	4	(0.2)	3	(0.1)	19	(0.8)	3	(0.1)	3	(0.1)	33	(1.5)	24	(1.1)
Wheatfield	**3499**	28	(0.8)	2	(0.1)	695	(19.9)	0	(0.0)	2936	(83.9)	546	(15.6)	333	(9.5)
Cloverhill	**1868**	24	(1.3)	2	(0.1)	445	(23.8)	48	(2.6)	1350	(72.3)	309	(16.5)	203	(10.9)
St Patrick's Institution	**295**	1	(0.3)	0	(0.0)	33	(11.2)	0	(0.0)	40	(13.6)	11	(3.7)	38	(12.9)
Castlerea	**118**	5	(4.2)	0	(0.0)	40	(33.9)	1	(0.8)	20	(16.9)	23	(19.5)	28	(23.7)
Loughan House	**218**	3	(1.4)	4	(1.8)	50	(22.9)	1	(0.5)	0	(0.0)	29	(13.3)	84	(38.5)
Shelton Abbey	**384**	20	(5.2)	3	(0.8)	25	(6.5)	8	(2.1)	0	(0.0)	10	(2.6)	61	(15.9)
Limerick (Male and Female)	**793**	21	(2.6)	5	(0.6)	309	(39.0)	5	(0.6)	633	(79.8)	142	(17.9)	125	(15.8)
Cork	**67**	4	(6.0)	2	(3.0)	16	(23.9)	0	(0.0)	11	(16.4)	3	(4.5)	11	(16.4)
Midlands	**2756**	20	(0.7)	10	(0.4)	807	(29.3)	7	(0.3)	2563	(93.0)	818	(29.7)	412	(14.9)
Portlaoise	**332**	4	(1.2)	0	(0.0)	83	(25.0)	0	(0.0)	214	(64.5)	75	(22.6)	57	(17.2)
Arbour Hill	**8**	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)	0	(0.0)

*Results exclude all committals.

Source: Irish Prison Service, unpublished data, 2011

Neuroscience and addiction recovery – NEAR conference

The first international NEAR conference took place in Wicklow over three days from 10 November 2011. There were three objectives:

- to introduce delegates to Irish and international experts in the field of addiction;
- to explore the latest neurological developments on potential causes and treatments;
- to educate delegates about the latest evidence based recovery practices and their application.

The multi-disciplinary audience was composed primarily of counsellors, psychotherapists and other practitioners. Presentations explored issues arising from a range of addictions such as gambling, food, sex, and videogames, as well as alcohol and drugs.

Contributors to the NEAR conference: Paddy Creedon, Brendan Murphy and Oisin McConville

Some keynote speakers focused the neuroscience of addiction. For example, Dr Shelly Uram showed how psychological trauma can impact the brain and subsequent behaviour. She described how the effects of trauma are

NEAR conference *(continued)*

stored in the brain's survival areas implicated in flight, fight or freeze (shut-down or depressed) responses. Therapies such as EMDR (Eye movement desensitization and reprocessing) may be required to reach these ancient 'unconscious' brain areas before 'talking therapies' are of use. She also suggested that recovery goes beyond stopping using addictive substances or behaviours, and means recovering one's underlying true nature, which can be helped through processes such as 12-step. (To view videos on this topic by Dr Uram visit www.youtube.com/watch?v=6926eENqzwg.)

In another keynote address, Dr Carlton Erickson described addiction as a chronic, relapsing brain disease causing out-of-control behaviour. Drugs (including alcohol) are associated with specific neurotransmitters (chemicals which allow the transmission of signals from one brain neuron to the next). It is assumed that for some people genetics, drug use and, possibly, environmental issues lead to dysregulation of the neurotransmitter system leading to compulsive use. People may get better through various types of treatment, such as psychosocial therapies, which 'push back' this system towards normal function. (For more information visit the University of Texas Addiction Science Research and Education Center at www.utexas.edu/research/asrec/.)

Workshop sessions of 90 minutes gave presenters ample time to illustrate and discuss treatment topics such as mindfulness, group analytic psychotherapy, experiential therapies, oxygen therapy, and EMDR. Wider issues, such as the doctors' role in addiction practice, dual diagnosis, including families in recovery, and the development of Irish drug and alcohol policy, were also included.

In one of these sessions, Brendan Murphy and Paul Goff spoke about the development of the alcohol and substance abuse prevention (ASAP) programme in the Gaelic Athletic Association (GAA), which helps clubs prevent and respond to problems. A new brief intervention training programme based on the SAOR model[1] has been introduced for coaches. They are taught to **S**upport, **A**sk and assess, **O**ffer assistance and **R**efer players with substance-related issues for help. This intervention has the potential to reach large numbers of amateur sportsmen, who have reported high rates of alcohol consumption and alcohol-related harm.[2]

For more information about the conference programme and speakers visit the Toranfield House conference website www.nearconference.com. The 2012 conference is scheduled to take place between 8–10 November.

(Mary Dunne)

1. O'Shea J and Goff P (2011) SAOR model. *Screening and brief interventions for problem alcohol use in the emergency department & acute care settings*. Waterford: Health Service Executive. www.drugsandalcohol.ie/15791
2. O'Farrell A, Allwright S, Kenny S, Roddy G and Eldin N (2010) Alcohol use among amateur sportsmen in Ireland. *BMC Research Notes*. 3:313. www.drugsandalcohol.ie/14227

ACAMH youth mental health conference

The Association for Child and Adolescent Mental Health special interest group, Youth Mental Health, held its first national research conference, Emerging evidence on youth mental health: multi-disciplinary perspectives, on 14 October 2011.

Dr Bobby Smyth speaking at the ACAMH conference

The morning session focused on the rights of the child, with a talk by Emily Logan, Ombudsman for Children, and the launch of the *International Declaration on Youth Mental Health*, which sets out a range of measurable targets to be achieved over a 10-year period.[1]

Research on recognising mental health problems and on working towards solutions was then presented. A number of speakers quoted from Kessler and colleagues,[2] whose study found that half of all cases of mental illness start by age 14 years and three quarters by age 24 years. This key message underlined the importance of understanding and tackling mental health issues among young people.

The final session of the day centred on substance use among young people. Dr Bobby Smyth outlined a descriptive study of adolescents assessed at the Drug Treatment Centre Board.[3] He highlighted the multiple and complex needs of teenagers who abused opiates, and concluded that services will require a broad range of interventions and effective interagency co-operation in order to meet these needs. Details of a recently published study on the outcomes for heroin-dependent adolescents were also provided.[4] Professor Walter Cullen closed this session with a presentation about the role of community-based practice for mental and substance use disorders.[5]

The following services presented information about their work at the conference:

- *Jigsaw*: a network of projects working with communities to better support young people's mental health www.jigsaw.ie
- *Working Things Out*: a therapeutic resource for adolescents dealing mental health problems www.workingthingsout.ie
- *Inspire Ireland*: which manages http://ie.reachout.com, an online service to help young people aged 16–25 get through tough times.

(Mary Dunne)

1. Buckley S, Canon M, Chambers D, Coughlan H, Duffy M, Gavin B et al. (2011) *International Declaration on Youth Mental Health*. Dublin: Association for Child and Adolescent Mental Health. www.drugsandalcohol.ie/16297
2. Kessler RC, Berglund P, Dernler O, Jin R, Merikangas KR and Walters EE (2005) Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry*, 62(6): 593–602. http://archpsyc.ama-assn.org/cgi/content/abstract/62/6/593
3. Fagan J, Naughton L and Smyth BP (2008) Opiate-dependent adolescents in Ireland: a descriptive study at treatment entry. *Irish Journal of Psychological Medicine*. 25(2): 46–51. www.drugsandalcohol.ie/12407

ACAMH youth mental health conference *(continued)*

4. Smyth BP, Fagan J and Kernan K (2012) Outcome of heroin-dependent adolescents presenting for opiate substitution treatment. *Journal of Substance Abuse Treatment*. 42(1):35–44. www.drugsandalcohol.ie/15964

5. Cullen W, Broderick N, Connolly D and Meagher D (2011) What is the role of general practice in addressing youth mental health? A discussion paper. *Irish Journal of Medical Science*, Early online. www.drugsandalcohol.ie/16025

MQI annual review 2010

The Merchants Quay Ireland (MQI) annual review for 2010 was launched on 30 September 2011 by the Minister of State at the Department of Health, Róisín Shortall TD.[1]

2010 saw the development of a number of important new initiatives at MQI. These initiatives are the Extended Day Service developed in association with Focus Ireland, New Communities Support Service, Midlands Traveller Specific Drugs Project, Aftercare Housing in conjunction with Respond Housing Association, Drug Free Day Programme and Easy Access Education for Homeless People

The review also provides additional information that is not fully reflected in the treatment figures recorded by the National Drug Treatment Reporting System (NDTRS).

MQI's needle-exchange service recorded approximately 25,000 client visits in 2010, a 20% decrease on 2009 figures. The report highlights a continuing high level of demand for homeless services, with 57,840 meals provided in 2010. The number of health care interventions provided increased by 15% to 3,685 in 2010.

In 2010 MQI successfully tendered to provide the national prison-based addiction counselling service to 13 prisons. In excess of 13,000 counselling hours were provided during 2010. This service is provided by 23 counsellors, each with an average caseload of 550 prisoners.

MQI in association with the Midland Regional Drugs Task Force administers the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The family support service provided services to 237 new clients across the region during 2010. The harm reduction service provided needle-exchange services to an average of 124 clients each month during 2010.

The services offered by MQI and the numbers of people accessing them in 2010 are shown below.

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	Promotes safer injecting techniques HIV and hepatitis prevention Safe sex advice Information on overdose Early referral to drug treatment services	4308 used needle-exchange services, of whom 575 were new clients 1,617 safer injecting workshops	
Stabilisation services	Methadone substitution Supportive day programmes Gateway programme Counseling	19 78 (monthly average)	
Settlement service	Assists service users to access interim and long-term accommodation	74 (quarterly average)	45 clients were resettled.
Integration programmes	Access to transitional accommodation Ballymount House Group and one-to-one therapeutic sessions	3 (annual average)	
Training and work programmes	FÁS Community Employment scheme	90	Of the 26 who completed FÁS placements at Merchants Quay, 6 secured permanent employment, 2 moved to further education.
High Park	17-week, drug-free residential programme including individual counseling, group therapy, educational groups, work assignments and recreational activities	62 (of whom 13 were admitted for detoxification)	10 clients completed detox
St Francis Farm	Therapeutic facility offering a 6–12-month programme.	34	11 clients completed three months or more

(Vivion McGuire)

1. Merchants Quay Ireland (2011) *Annual review 2010*. Dublin: MQI. Available at www.mqi.ie

Drugs in focus – policy briefing

Responding to new psychoactive substances

Cited from *Drugs in focus,* No. 22, 2nd issue 2011

Key issues at a glance

1. New psychoactive substances are not easily detected and identified by forensic laboratories. This may hinder targeted and timely responses by legislators and law enforcement.
2. It is not legally possible to criminalise the unauthorised distribution of all psychoactive substances, so legislation, rather than being proactive, can only react to substances as they appear.
3. New psychoactive substances may pose risks to individual and public health as well as social risks, affecting the broader community. However, when they first appear on the market, information on their associated risks is lacking.
4. The legislative procedure required to bring a substance under the control of the drug laws takes time, in some countries more than a year.
5. Controlling a new psychoactive substance might have unintended and unwanted consequences. It may stimulate the search for, and distribution of, a non-controlled replacement, possibly one more harmful than its predecessor.
6. Other control options, though faster, lack the penalties to send the same messages of deterrence and health risk. Furthermore, they might not be effective in preventing or stopping the marketing and distribution of a new substance.

Conclusions and policy considerations

1. Detecting and identifying new psychoactive substances as they appear on the market are the first steps to assessing the risks of, and ultimately controlling, potentially dangerous new drugs. The capacity to achieve this task is an essential element of early-warning systems.
2. Risk assessment systems can provide evidence to support the legislative process. Targeted research is key to providing a firm evidence base for risk assessment and for ongoing justification of control measures.
3. Striking the right balance between swiftness of response to new substances, on the one hand, and sufficient scientific evidence and legislative supervision, on the other, is an important policy goal.
4. Drug laws should address substances that pose serious health and social threats. Other measures, combined with prevention programmes, may also be used to dissuade the use of non-controlled substances that are not necessarily safe.
5. It is important to consider if other laws already available, such as consumer protection and medicines laws, might achieve the desired objective. Speed of reaction may be more important than severity. Import bans can reduce pressure on local enforcement mechanisms.
6. The European Commission, in co-operation with EU countries, the EMCDDA and Europol, is working on new legislation to better address the control of new psychoactive substances throughout the EU.

From *Drugnet* Europe

Drugs and driving

Cited from article by Brendan Hughes in *Drugnet Europe*, No. 76, October–December 2011

Many countries around the world are now developing solutions to deal effectively with the problem of drugs and driving. In July 2011, the Canadian Centre on Substance Abuse (CCSA) — in partnership with the EMCDDA, the United States Office of National Drug Control Policy (ONDCP) and the US National Institute on Drug Abuse (NIDA) — hosted the first international symposium on the subject in Montreal, Canada.

The purpose of the symposium was to build on the 2011 resolution on drugged driving adopted by the UN Commission on Narcotic Drugs. This recognises the importance of a coordinated approach to addressing the health and public safety consequences of this practice, through evidence-based research. A final report on the symposium will be published on the CCSA website (www.ccsa.ca).

In Europe, the complex issue of drugged driving has been the subject of the multi-country DRUID project (Driving under the influence of drugs, alcohol and medicines), which held its final conference in September 2011. The EUR 24 million project, which has published over 30 reports ('see deliverables') on its website, used harmonised data-collection protocols to examine the effects of these substances on road safety (www.druid-project.eu).

Overdose deaths — just the tip of the iceberg?

Cited from *Drugnet Europe*, No. 76, October–December 2011

Over 7 600 fatal overdoses were reported in the EU and Norway in 2009, with opioids associated with the majority of these. But studies suggest that overdose deaths could be just the tip of the iceberg. A *Selected issue* publication on drug-related mortality published alongside the Annual report estimates that around 10 000 to 20 000 problem opioid users could be dying each year in Europe, mainly from overdose, but also from diseases, suicide and trauma.

The review looks at the 'excess mortality' in regular opioid users (risk of death compared with the general population) and finds that their risk of dying is 10 to 20 times higher than for their non-drug-using peers. The report underlines the role that services can play in reducing the human costs of long-term drug problems. Under evaluation in some countries are programmes targeting periods known to be risky for opioid users (e.g. leaving prison, dropping out of treatment).

Drugnet Europe is the quarterly newsletter of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). ***Drugs in focus*** is a series of policy briefings published by the EMCDDA. Both publications are available at **www.emcdda.europa.eu**.

If you would like a hard copy of the current or future issues of either publication, please contact:

Health Research Board, Knockmaun House,
42–47 Lower Mount Street, Dublin 2.
Tel: 01 2345 148; Email: drugnet@hrb.ie

In brief

On 6 June 2011 the **Pharmaceutical Society of Ireland** presented the Minister for Health, Dr James Reilly TD, with the results of the first baseline research into community pharmacy practice in Ireland. A key element of the research was to examine the current service offering within pharmacies across the country, with a particular emphasis on the extent of the provision of 'enhanced pharmacy services', i.e. 'services implemented in pharmacies that are additional to or not routinely provided with prescribed or non-prescribed medicines'. The following table outlines the responses with regard to two drug-related services. www.pharmaceuticalsociety.ie

	Currently provided		Not currently provided, would like to provide in future		Not currently provided, would not like to provide in future	
	n	%	n	%	n	%
Supervised methadone service	140	36.1	74	19.1	174	44.8
Needle exchange	10	2.7	128	35.1	227	62.2

Between 22 and 24 September 2011 the **European Society for Social Drug Research** held its 22nd annual conference in Aarhus, Denmark. The results of two Irish research projects were presented. (1) A longitudinal pathways analysis of drug use among homelessness young people (Paula Mayock and Mary Louise Corr). The presenters focused on the relationship between the homeless and drug pathways. They described a connection between downward transitions in drug consumption and positive housing experiences, on the one hand, and upward transitions in drug use and chronic housing instability, on the other. They argued for a conceptual shift towards a focus on *housing*, rather than homelessness, when attempting to explain change in the drug consumption patterns of young people who negotiate the experience and consequences of homelessness during the transition to adulthood. (2) A qualitative study, using grounded theory, of treatment-seeking among heroin users (Anne McDonnell and Marie van Hout). Describing the social and contextual factors which enable change in perception of heroin use, recovery and treatment, the study supports the view that the concept of 'turning points' in the life course are valuable when thinking about how people give up the use of drugs. www.essd-research.eu

In September 2011 Issue 67 of **Working Notes**, the journal of the Dublin-based **Jesuit Centre for Faith and Justice**, included an article by Fr Peter McVerry SJ, in which he calls for a radical appraisal of current approaches to dealing with illegal drug use. Pointing out that 'drug policy' encompasses both policies to deal with the supply of drugs and policies to deal with demand, he says that addressing supply absorbs by far the greater share of public expenditure. Yet, despite successes in intercepting supplies, the inflow of drugs continues, with powerful criminal gangs controlling this trade. He suggests that the findings and recommendations of the Global Commission on Drug Policy, published in June 2011, provide some useful guidelines for the much-needed public and political debate on the issue.[1] In relation to policies to control demand, Fr McVerry highlights the importance of addressing demand among those who are habitual users or who are addicted to drugs. He emphasises the need for a comprehensive range of detoxification, rehabilitative and after-care services, and says that it is essential that these be accessible without undue delays. While the importance of all these elements has long been recognised in official policy and strategy statements, provision falls far short of need, and existing services are endangered by current cutbacks in public funding. www.workingnotes.ie

In September 2011 the **Council of Europe** published ***Some still more equal than others? Or equal opportunities for all?***. The author of the report described research showing that inequality – in opportunities, wealth or health – is widespread in Europe and that the citizens of richer countries do not necessarily have healthier profiles than those of poorer countries; moreover, the citizens of egalitarian countries have the highest life expectancy. http://book.coe.int/EN

On 1 November 2011 **Merchants Quay Ireland** opened its new fully medically supervised residential detox unit at St Francis Farm, Tullow, Co Carlow. For referrals and further information please contact Rose Sheppard, Clinical Nurse Manager, Sycamore House, St Francis Farm, Tullow, Co Carlow, Tel: 087–9603905, e-mail: rose.sheppard@mqi.ie

On 18 November 2011 the annual reports for 2010 of the **Prison Visiting Committees** to Arbour Hill, Cloverhill, Castlerea, Cork, Dóchas Centre, Limerick, Loughan House, Midlands, Mountjoy, Portlaoise, Shelton Abbey, St Patrick's Institution, the Training Unit and Wheatfield were launched. www.justice.ie

On 30 November 2011 the **Central Statistics Office** published the preliminary results of the ***2010 Survey on Income and Living Conditions (SILC)***. Ireland's official source of data on household and individual income, including key national poverty indicators, SILC 2010 shows the following changes since the 2009 survey:

- Average annual equivalised disposable income (i.e. household income adjusted for household composition) dropped by 5%, from €23,326 in 2009 to €22,168 in 2010.
- Income inequality increased, with the average income of those in the highest income quintile being 5.5 times that of those in the lowest income quintile, compared to 4.3 one year earlier.
- Although the at-risk-of-poverty threshold decreased by more than 10% in 2010, the at-risk-of-poverty rate rose by 1.7%, from 14.1% in 2009 to 15.8% in 2010.
- The deprivation rate (those experiencing two of more types of enforced deprivation) rose by nearly 6%. This increase was largely attributable to an increase in the deprivation rate among those NOT at risk of poverty, from 13.7% in 2009 to 19.3% in 2010. www.cso.ie

(Compiled by Brigid Pike)

1. See 'In brief' in Issues 37 and 39 of *Drugnet Ireland* for a short account of the work and final report of the Global Commission on Drug Policy.

Recent publications

Journal articles

The following abstracts are cited from recently published articles relating to the drugs and alcohol situation in Ireland.

Brief interventions are effective in reducing alcohol consumption in opiate-dependent methadone-maintained patients: results from an implementation study

Darker C, Sweeney B, El Hassan HO, Smyth BP, Ivers, JH and Barry J
Drug and Alcohol Review, 2011, September, Early online
www.drugsandalcohol.ie/15943

This study aimed to test the feasibility and effectiveness of brief interventions (BIs) to reduce hazardous and harmful alcohol consumption in opiate-dependent methadone-maintained patients. Methods involved before and after intervention comparison of Alcohol Use Disorders Identification Test (AUDIT-C) scores from baseline to three-month follow up. Seven hundred and ten (82%) of the 863 eligible methadone-maintained patients within three urban addiction treatment clinics were screened. A WHO protocol for a clinician-delivered single BI to reduce alcohol consumption was delivered. One hundred and sixty (23% of overall sample screened) 'AUDIT-positive' cases were identified at baseline screening with a mean total full AUDIT score of 13.5 (SD 6.7). There was a statistically significant reduction in AUDIT-C scores from T1 to T2 for the BI group. There was a statistically significant decrease in the proportion of men who were AUDIT-positive from T1 to T2. The authors conclude that it is feasible for a range of clinicians to screen for problem alcohol use and deliver BI within community methadone clinics. Opiate-dependent patients significantly reduced their alcohol consumption as a result of receiving a BI.

Does concurrent cocaine use compromise 1-year treatment outcomes for opiate users?

Cox G and Comiskey C
Substance Use and Misuse, 2011; 46(9): 1206–1216.
www.drugsandalcohol.ie/14865

This study aimed to determine whether cocaine use compromises treatment outcomes for opiate users. Data were collected from 404 opiate users at treatment intake and 1-year follow-up as part of a national treatment outcome study. Because of higher intake measures, cocaine users improved in more outcomes than nonusers, but comparisons between groups found that cocaine users had more coexisting problems. Regression analysis revealed that those who used cocaine at intake were more likely to use cocaine at 1-year follow-up, to commit crime, and to be homeless. It is concluded that treatment for opiate use 'works' even in the presence of concurrent cocaine use.

Users, carers and professionals experiences of treatment and care for heroin dependency: implications for practice. A preliminary study

Braden M, McGowan IW, McLaughlin DF, McKenna H, Keeney S and Quinn B
Journal of Substance Use, 2011; 16(6): 452–463.
www.drugsandalcohol.ie/16653

This paper reports on the treatment and care experiences for heroin dependency in a Northern Ireland healthcare trust. Focus groups were undertaken with separate purposive samples of ex//current heroin users (n = 7), carers of ex//current heroin users (n = 4) and professionals involved in heroin dependency service provision (n = 4). Non-directive question schedules elicited collective phenomenological experiences. Focus groups were transcribed verbatim and content analyzed.
Findings: Study participants shared mainly dehumanizing experiences of treatment and care provision often characterized by non-communicative and judgemental health professional conduct. Unpredictable prescribing protocol and limited treatment resources overshadowed any beneficial experiences of substitute prescribing in our pilot study. Findings also showed that participants requested treatment choice and holistic care provision. Conclusions: Incoherent drug treatment policy and communication breakdown between treatment stakeholders has influenced a cyclical blame culture in this study.

Area of residence and alcohol-related mortality risk: a five-year follow-up study

Connolly S, O'Reilly D, Rosato M and Cardwell C
Addiction, 2011; 106(1): 84–92.
www.drugsandalcohol.ie/14503

This was a five-year longitudinal study of individual and area characteristics of those dying and not dying from alcohol-related deaths.
Participants: A total of 720,627 people aged 25–74, enumerated in the Northern Ireland 2001 Census, not living in communal establishments.
Findings: There was an increased risk of alcohol-related mortality among disadvantaged individuals, and divorced, widowed and separated males. The risk of an alcohol-related death was significantly higher in deprived areas for both males [hazard ratio (HR) 3.70; 95% confidence interval (CI) 2.65, 5.18] and females (HR 2.67 (95% CI 1.72, 4.15); however, once adjustment was made for the characteristics of the individuals living within areas, the excess risk for more deprived areas disappeared. Both males and females in rural areas had a reduced risk of an alcohol-related death compared to their counterparts in urban areas; these differences remained after adjustment for the composition of the people within these areas.
Conclusions: Alcohol-related mortality is higher in more deprived, compared to more affluent areas; however, this appears to be due to characteristics of individuals within deprived areas, rather than to some independent effect of area deprivation per se. Risk of alcohol-related mortality is lower in rural than urban areas, but the cause is unknown.

Over-the-counter medicine abuse – a review of the literature

Cooper RJ
Journal of Substance Use, 2011, 3 October; Early online
www.drugsandalcohol.ie/16456

This review describes the current knowledge and understanding of OTC medicine abuse, as found in a comprehensive search of international empirical and review literature between 1990 and 2011. Findings were: OTC medicine abuse was identified in many countries and although implicated products varied, five key groups emerged: codeine-based (especially compound analgesic) medicines, cough products (particularly dextromethorphan), sedative antihistamines, decongestants and laxatives. No clear patterns relating to those affected or their experiences were identified and they may represent a hard-to-reach group, which coupled with heterogeneous data, makes estimating the scale of abuse problematic. Associated harms included direct physiological or psychological harm (e.g. opiate addiction),harm from another ingredient (e.g. ibuprofen-related gastric bleeding) and associated social and economic problems. Strategies and interventions included limiting supplies, raising public and professional awareness and using existing services and internet support groups, although associated evaluations were lacking. Terminological variations were identified.

Conclusions: OTC medicine abuse is a recognised problem internationally but is currently incompletely understood. Research is needed to quantify scale of abuse, evaluate interventions and capture individual experiences, to inform policy, regulation and interventions

drugnet IRELAND

Upcoming events

(Compiled by Joan Moore – jmoore@hrb.ie)

February

17 February 2012

CityWide call for drug alliance initiative, and launch of policy document and film
Venue: Liberty Hall Theatre, Dublin 12:30pm
Organised by: CityWide Drugs Crisis Campaign
Email: info@citywide.ie
www.citywide.ie

Information: CityWide emerged from a mass meeting of community activists and local residents which took place in Liberty Hall in 1995. Seventeen years later we are inviting all those interested in finding ways of collaborating to respond to the devastating impact of the continuing drugs crisis. We believe it's time to build a broad alliance campaign to put the drugs crisis in our communities back on the political agenda. The event will bring together people working in community projects, community representatives, trade unions, academics, faith communities, public representatives and community networks.

The CityWide film will have its first showing at this event. Filmed during 2010, this project set out to show how drugs have impacted on communities, how those communities have responded, how national drugs strategies developed and how CityWide has worked locally and nationally.

The CityWide 4th policy document will be launched. Based on wide consultation with community representatives and projects, drugs task forces and others, our new policy document highlights the continuing drugs crisis, it explains its complexity and impacts and it makes practical proposals.

March, May and June

Managing the Performance, Safety and Health Risks of Employee Drug and Alcohol Use
Venues: Various
Organised by / Contact: EAP Institute
Email: anita@eapinstitute.com
www.eapinstitute.com
Tel: +353 (0)51 855 733

Thursday 1 March 2012
Cork, Rochestown Park Hotel

Thursday 17 May 2012
Galway, Carlton Hotel

Thursday 14 June 2012
Portlaoise, Heritage Hotel

Information: An information sheet on intoxicants at work posted on the Health & Safety Authority (HSA) website on 20 September 2011 confirmed that the HSA will not be issuing any codes of practice or regulations on intoxicant testing. Where testing is part of company policy or forms part of employee contracts, it is recommended that the testing should be carried out in accordance with a recognised standard such as the European Workplace Drug Testing Society (EWDTS) Guidelines for legally defensible drug testing.

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Managing editor:
Brian Galvin
Editor: Joan Moore

The purpose of this seminar is to outline an approach that companies can implement, in managing the performance, safety and health
risks of employee drug and alcohol abuse. Seminar speakers and topics will include:

Maurice Quinlan – Guidance on Developing a Comprehensive Approach to Workplace Intoxicants (defined as drugs and alcohol);

Michael Magennis – European Workplace Drug Testing Society (EWDTS) Guidelines on Legally Defensible Workplace Drug Testing.

May

30–31 May 2012

Sixth Annual Conference of the International Society for the Study of Drug Policy
Venue: Cathedral Lodge, Canterbury
Organised by / Contact: ISSDP
www.issdp.org/conferences.php

Information: This event will be hosted by the University of Kent (School of Social Policy, Sociology and Social Research). The call for abstracts is now open. For details, please see ISSDP website. The invited keynote speakers are:

Professor Thomas McLellan, University of Pennsylvania (formerly Deputy Director of the US Office for National Drug Control Policy)

Dr Michel Kazatchkine, Executive Director of the Global Fund and member of the Global Commission on Drug Policy.

Dr Fiona Measham, University of Lancaster and member of the UK Advisory Council on the Misuse of Drugs

Martin Jelsma, Transnational Institute

The conference will discuss a wide range of drug policy issues, with a particular focus on 'how can and do empirical studies influence drug policy?

July

2–13 July 2012

ISCTE–EMCDDA summer school on illicit drugs
Venue: Lisbon
Organised by / Contact:
Email: drugsummerschool.cies@iscte.pt
www.drugsummerschool.cies.iscte-iul.pt/np4/home

Information: The Lisbon-based Instituto Superior das Ciências do Trabalho e da Empresa (ISCTE) and the EU drugs agency (EMCDDA) are currently collaborating on a summer school programme ent itled: 'Illicit drugs in Europe: supply, demand and public policies'. During the two-week course, EMCDDA scientific experts, ISCTE-professors and policymakers, will prepare participants to meet the complex policy challenges in this field, by providing a multi-disciplinary and inclusive approach to the study of the drug problem, both in Europe and beyond. The target audiences for the summer school are university students (undergraduate and graduate), researchers, professionals and administrators interested or working in the drugs field. ECTS credits will be given for the courses and students can transfer credits to other European universities using the ECTS-system